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British Medical Association

SUPPLEMENTARY ANNUAL REPORT OF COUNCIL, 1946-7

Every member is asked to keep this Supplement, with the earlier one of April 26, until the subjects have been discussed by his Division.

CONTENTS

PRELIMINARY

Commemoration of the One Hundredth Anniversary of the American Medical Association

137. The Council has presented to the American Medical Association a gavel and block bearing the following inscription:

TO THE AMERICAN MEDICAL ASSOCIATION ON THE OCCASION OF ITS CENTENARY
AS A TOKEN OF GOOD WILL FROM THE BRITISH MEDICAL ASSOCIATION
THIS GAVEL AND BLOCK MADE FROM THE MULBERRY TREE
WHICH GREW
IN THE GARDEN OF CHARLES DICKENS'S HOME IN LONDON
WHERE THE BRITISH MEDICAL ASSOCIATION HOUSE NOW STANDS
JUNE, 1947

Health Centre Committee

138. The Council has appointed a special committee to investigate and report on existing forms of group practice, including partnerships and other forms of collaboration between general practitioners, and to relate this and other experience to health centre development. The primary purpose of the committee is to conduct a fact-finding inquiry, and the field-work will be undertaken by Dr. Revans, one of the Assistant Secretaries appointed recently. The committee aims to complete its investigations in time to enable its report to be published by the end of the year.

GENERAL PRACTICE

Fees for Medical Examination in connexion with Life Insurance

(Continuation of para. 21 of Annual Report)

139. Negotiations have been continued with the Life Offices' Association with a view to reaching agreement, either for the amendment of certain exceptionally lengthy medical report forms, or for the payment of a higher fee than £1 11s. 6d. for their completion. The Life Offices' Association has now intimated that it is expected that all the companies affected will be prepared to take steps to modify their forms of medical report on the lines indicated.

The attention of the Council has been drawn to the fact that the revised scale of fees is being applied in cases where the practitioner is required to visit the proposer for the purpose of carrying out the examination. The Life Offices' Association has been informed that the agreed fees relate only to examinations at the doctor's surgery, and that where he is required to carry out a domiciliary examination an additional fee of 5s. should be paid, with mileage at the rate of 1s. per mile each way, beyond 2 miles.

Certificates of Vaccination required by Passengers to Hong Kong and Singapore

140. The attention of the Council has been drawn to instructions issued to passengers to Hong Kong and Singapore that they must be able to produce certificates of vaccination signed by a medical officer of health or Government medical officer, and not by a general practitioner. The question has been raised with the Colonial Office, and the Department has replied to the effect that the position had already been taken up with the Governments concerned and that the Government of Hong Kong did not intend to proceed with the requirement. No reply from Singapore had yet been received, but in the meantime the Ministry of Transport had been requested to inform shipping and aircraft companies that they should continue to advise passengers sailing to Hong Kong and Singapore that they must be in possession of a certificate of recent vaccination, but without specifying that it should be signed by a central or local government medical officer.

Remuneration of Civilian Medical Practitioners

(Continuation of para. 26 of Annual Report)

141. Consequent upon the increase in the fees payable to practitioners under the National Health Insurance Act the War Office proposes as from Jan. 1, 1946, to make the following adjustment in the remuneration of civilian medical practitioners employed by the Department on a capitation basis:

For less than 10 persons, £10 15s. per annum in place of £7 14s. per annum.

For 10 or more, for every 25 or part of 25, £21 10s. per annum in place of £15 8s. per annum.

The Department is being pressed to give urgent consideration to the Council's representations for an improvement in the daily rates payable to civilian practitioners employed on full or part-time duties, and in the scale of payments for occasional attendances on a per-case basis.

Parking of Cars in Central London

142. The position of practitioners in London has been reviewed in the light of the recent decision to introduce a "no-parking" rule in certain streets in central London. The Council does not feel that the rule is likely to cause any great inconvenience to the profession in view of the fact that in general the streets affected are non-residential. It proposes, however, to ask the Commissioner of the Metropolitan Police whether a practitioner called to a sudden emergency would be allowed to park his car in a prohibited area, as an ambulance is permitted to do.

Independent Referees of the Ministry of Labour

143. The Council has urged the Ministry of Labour that the time is now opportune for the work carried out by Independent Medical Referees of the Ministry to be dealt with by medical boards.

Medical Examination of Recruits to the Territorial Army

144. Consequent upon the reconstitution of the Territorial Army, practitioners throughout the country are being approached to undertake the medical examination of recruits. The fees laid down by the War Office are as follows:

5s. per examination, subject to a maximum of
£4 4s. for the first and second days,
£3 13s. 6d. for the third day,
£3 3s. for the remaining days in any one week.

The Council feels that the experience of the war years has shown that examinations of this kind are most effectively carried out by the method of medical boards, and the War Office is being urged to adopt this procedure. In the meantime representations are also being made that the fee for these examinations should be 15s. per recruit examined, with no over-riding limit, and that clerical assistance should be provided in all cases.

Medical Examination of Merchant Seamen

145. Representations have been made to the Shipping Federation that the fee payable for the medical examination of merchant seamen under the Established Services Scheme should be increased to £1 1s.

Capitation Fee for the Treatment of Ex-Regular Firemen

146. Following representations to the Home Office regarding the capitation fee payable for medical attendance upon ex-regular members of the National Fire Service whose incomes do not exceed £420 per annum, the Department has decided to increase the fee to 19s. per head per annum with retrospective effect to Jan. 1, 1946. As this fee is inclusive of the supply of medicines, it is proposed to press for a further adjustment in accordance with the recent increase in the National Health Insurance dispensing fee.

Election of a Direct Representative on the General Medical Council

(Continuation of para. 30 of Annual Report)

147. The Council has pleasure in reporting that Dr. J. A. Brown has been elected a Direct Representative of the profession on the General Medical Council.

National Coal Board: Medical Examination of Miners and Sickness Certificates

148. Complaints have been received that in the South Wales coal mining area a stereotyped form of sickness certificate has been introduced by the National Coal Board and practitioners are being informed that no other certificate will be recognized. Whilst the local profession has no objection to the form in question it strongly opposes the compulsory use of any particular form. The Council supports this view and has approached the National Coal Board on the question.

The Council is also taking up with the National Coal Board the question of the examination of new entrants into the mining industry, and is suggesting that the most appropriate method of examination for service in the mines is by medical board.

Remuneration of Members of Recruiting Medical Boards

149. The Council proposes to make representations to the Ministry of Labour that the remuneration of members of Recruiting Medical Boards should be increased to £3 13s. 6d. per session in the case of chairmen and £3 3s. per session in the case of members.

In cases where the examination of recruits to H.M. Forces is carried out by individual practitioners the Council is urging that the present fee of 4s. be increased to 15s. per recruit examined.

Medical Attendance on Trainees at Government Training Centres

150. Representations have been made to the Ministry of Labour that the scale of fees for medical attendance on trainees at Government training centres, who are ineligible for treatment under the National Health Insurance Acts, should be increased as follows:

	From	*To*
Attendance at surgery (with medicine) ..	3s. 6d.	5s. 0d.
Day visit (with medicine)	5s. 0d.	7s. 6d.
Night visit (i.e., between 8 p.m. and 8 a.m.)	10s. 6d.	£1 1s. 0d.

and that mileage should be paid at the rate of 1s. per mile or part of a mile each way after the first 2 miles.

Fees for Medical Witnesses

151. Before the war evidence was submitted on behalf of the Association to a Departmental Committee appointed by the Home Office to consider the question of the allowances to witnesses in criminal courts, but the war intervened before this Committee had completed its task, and its deliberations were postponed until the end of hostilities. The Association's evidence, with minor amendments, was resubmitted to the Departmental Committee when it was reconstituted in 1946; and its report, which has now been published, has been reviewed by the Council.

The existing allowances, together with the Association's recommendations and those of the Departmental Committee, are set out below:

Existing Rate	Association's Recommendations	Departmental Committee's Recommendations
In the town where the practitioner resides or practises *One case*—not more than £1 11s. 6d. per day 2 *or more cases*—not more than £3 3s. 0d. per day *Elsewhere*—whether in one or more cases—£3 3s. 0d. per day	*Magistrates' Courts*—£3 3s. 0d. per day *Sessions or Criminal Courts*—£5 5s. 0d. per day	Not more than £5 per day, irrespective of the type of Court, and whether the practitioner attends in one or more cases, and in his home town or elsewhere

In the existing scale not more than half the maximum allowance may be paid unless the witness is detained for longer than 4 hours, and the Departmental Committee recommends that this practice shall continue save where the witness gives evidence on the same day in two or more separate cases.

Whilst, therefore, the proposed allowance would appear to be satisfactory, it should be noted that it is a maximum allowance, and whereas in the past it has been customary for the Court to pay the full allowance the Departmental Committee has emphasized that taxing masters should not hesitate to use their discretion, according to the individual circumstances of the case, in making allowances under the new scale. The Council will watch the position and decide future action in the light of the experience of practitioners called to give evidence in criminal cases. Representations have been made to the Home Office on the question of the Departmental Committee's recommendations relating to the travelling expenses of professional witnesses, and in particular it has been urged that first-class railway fares should be allowed, and that practitioners using their own cars should receive mileage at the rate of 1s. per mile each way.

There has in the past been considerable confusion in the profession as to when a practitioner was acting as a professional witness and when as an expert witness. The Council

is pleased to note that for the first time the Departmental Committee has defined these terms as follows:

"A professional witness means a witness who is a practising member of a profession, admission to which is subject to the passing of a qualifying examination, who in the ordinary practice of his profession acquires knowledge of the facts of the case before the Court and is called upon to give evidence as to those facts, or to express an opinion on such facts based on his general professional knowledge and experience.

"An expert witness means a witness, otherwise unconnected with the case, who because of his special scientific or professional knowledge, or other special qualifications, is called to give in evidence his expert opinion, either based on facts, or on the result of examination of material or data, submitted to him for the purpose."

Attention has also been given to the question of the fees payable to medical witnesses in civil cases, and the Lord Chancellor has been asked to receive a further deputation from the Association on this subject.

Domiciliary Attendance on Civilian War Injured Persons

152. At the beginning of the war agreement was reached with the Ministry of Health for the payment of a capitation fee of 16s. for each civilian (not being one eligible for treatment under the National Health Insurance Acts, or a child covered by the scheme of treatment of unaccompanied evacuated children) receiving domiciliary medical attention in respect of war injuries, the fee to cover a period of one year from the date of the first attendance.

The Council has urged the Ministry that a capitation method of payment is no longer appropriate for the diminishing number of persons receiving treatment under the foregoing arrangements, and that payment should be made on a per-case basis at the following rates:

Consultation	5s. 0d.
Day visit	7s. 6d.
Night visit	£1 1s. 0d.

with mileage at the standard rate of 1s. per mile.

NATIONAL HEALTH INSURANCE

Dispensing Capitation Fee

(Continuation of para. 51 of Annual Report)

153. The capitation fee paid to doctors in rural areas for supplying ordinary medicines, etc., to insured patients was 2s. 6d. in 1939. Increases of 6d. were obtained in October, 1940, and November, 1945, and negotiations have recently been completed which result in a further increase of 1s. 3d., with effect from Jan. 1, 1947, making a current fee of 4s. 9d., or 90% above the pre-war fee.

Pathological Facilities for Insured Persons

154. For many years the Ministry of Health has been pressed to provide a complete pathological service for use by medical practitioners for their insured patients. The Ministry is not prepared to extend the scope of the present N.H.I. medical service in this way, but an announcement has recently been made of the introduction of a partial service which is available to all general practitioners. It is known as the Public Health Laboratory Service and is under the direction of the Medical Research Council (for the Ministry of Health). In general, it covers all bacteriological examinations in the laboratory and observations in the field in relation to the diagnosis, prevention, and control of infectious disease other than venereal disease. It does not include clinical pathology. One of its advantages is that it affords an opportunity for consultation with the bacteriologist. Most of the Public Health laboratories are being absorbed into the Service and the Ministry is anxious that full use shall be made of it.

Shortage of Medicaments

(Continuation of para. 57 of Annual Report)

155. Representations have been made to the Ministry of Health on the shortage of liquid paraffin, olive oil, and glucose. The shortage of liquid paraffin is stated to be due mainly to the fact that supplies, though up to 1939 volume, are inadequate to meet the present increased demand. Regarding olive oil, the supply position is affected by the difference between the price demanded by the supplying countries and the price Great Britain is prepared to offer. The shortage of glucose is a reflection of the world shortage of cereals and there appears to be no prospect of an immediate improvement.

National Formulary

156. A third edition of the *National War Formulary* is to be issued in the near future and will remain in operation until the *Standard Prescribers' Formulary,* which is now being prepared by a joint committee of the B.M.A. and the Pharmaceutical Society, is brought into use under the proposed national health service.

SPECIAL PRACTICE

Bastardy (Blood Tests) Bill

157. The Council is making representations to the Home Office and the Ministry of Health in support of the reintroduction of the Bastardy (Blood Tests) Bill. This Bill, placed before a Select Committee of the House of Lords in 1939, and dropped upon the outbreak of war, provides that, in an application for an affiliation order, a Court may require the applicant, her child, and the defendant to undergo blood tests to ascertain whether such tests show that the defendant is excluded from being the father of the child.

Bentham Committee for Poor Litigants

158. The Council has had before it a request from the Bentham Committee for the names of medical practitioners prepared to give their services in providing, without remuneration, medical evidence in support of claims of poor litigants for compensation. From time to time disputes arise in workmen's compensation cases where the litigant, for financial reasons, is unable to secure suitable medical evidence to support his claim for compensation. Where these cases come to court, the Bentham Committee, after satisfactory investigation, arranges for free legal aid. It is pointed out that there are not likely to be more than twenty cases in a year, and the position is not likely to continue for a long time in view of the fact that under the National Insurance Industrial Injuries Act, 1946, the hearing of claims for medical benefit will be taken out of the courts.

The Council hopes that members of the profession, in common with members of the legal profession, will assist in the work of the Bentham Committee.

PUBLIC HEALTH

Public Assistance District Medical Officers

(Continuation of para. 85 of Annual Report)

159. The Council has reached the conclusion that there is a case for a general increase in the remuneration of district medical officers. In view of the extent to which district medical officers' terms of appointment vary throughout the country the Council's view is that action for any such increase could most effectively be taken locally with central assistance where necessary. Where payment is by salary the object is to secure the raising of salaries to a level which, allowing for variations due to changed duties, includes a 50% "betterment" factor as compared with pre-war remuneration for the appointment. Where payment is by capitation fee, the object is the implementation of the Association's policy that fees should be raised to a level which is not less favourable than that of National Health Insurance, bearing in mind that usually payment is per patient treated and that the incidence of sickness is greater. Divisions have accordingly been requested to undertake a review of the rates of remuneration paid to district medical officers in their areas, and to take the necessary action. They have been informed that all possible central support will be given.

Measles and Whooping-cough

160. In 1939 the Association informed the Ministry of Health that it could not agree to a fee of 1s. for notification of cases of measles and whooping-cough, which the Minister proposed to prescribe in regulations. The Measles and Whooping-cough Regulations, 1940, were nevertheless made, providing for a fee of 1s., and the Association registered a strong protest. The

fee in respect of the notifiable diseases specified in Section 343 of the Public Health Act, 1936, which do not include measles and whooping-cough, is 2s. 6d. for cases occurring in private practice. In making the regulations with a reduced fee, the Minister exercised his power, under Section 143 of the Act, of applying *with modification* the enactments relating to notifiable diseases. The Council has reaffirmed its view that the fee for notifying measles and whooping-cough should not be less than that prescribed for the notifiable diseases specified in the Public Health Act, and has requested the Ministry to amend the Measles and Whooping-cough Regulations accordingly.

International Vaccination Certificate

161. The Council has received from an unofficial source a copy of the International Vaccination Certificate, which is in the following form:

INTERNATIONAL CERTIFICATE OF VACCINATION AGAINST SMALLPOX

This is to certify that .....

(Age..... Sex.....) whose signature appears below has this day been vaccinated by me against smallpox.

Origin and Batch No. of vaccine .....

Signature of Vaccinator .....

Official Stamp Official Position .....

Place ..... Date .....

Signature of person vaccinated .....

Home Address .....

Important Note: In the case of primary vaccination the person vaccinated should be warned to report to a medical practitioner between the 8th and 14th day, in order that the result of the vaccination may be recorded on this certificate. In the case of revaccination the person should report within 48 hours for first inspection in order that any immune reaction which has developed may be recorded.

This is to certify that the above vaccination was inspected by me on the date(s) and with the result(s) shown hereunder:

Date of Inspection	Result
.....	.....
.....	.....
.....	.....

Signature of Doctor .....

Official Stamp Official Position .....

Place ..... Date .....

Use one or other of the following terms in stating the result, viz: "Reaction of immunity," "Accelerated reaction (vaccinoid)," "Typical primary vaccinia." A certificate of "No reaction" will not be accepted.

Signature of person vaccinated .....

(This certificate is not valid for more than 3 years from date of issue.)

The certificate was drawn up in 1944 by the International Sanitary Convention. Signatories of the Convention, among which is the United Kingdom, are being urged to adopt the certificate with the object of facilitating foreign travel. The Council's view, which has been communicated to the Ministry of Health, is that the certificate, placing as it does a duty on the profession, should have been brought officially to the Association's notice with an invitation for its comments. The Ministry at the same time has been asked to explain the difference between the terms "Reaction of Immunity" and "No reaction." It has also been pointed out that the second part of the certificate appears to require completion by a practitioner other than the vaccinator, which may be invidious for the latter.

MEDICAL ETHICS

Inter-professional Relationships between Doctor and Dentist

162. The Council, in consultation with the British Dental Association, has approved the following rules as a guide to inter-professional relationship between doctor and dentist:

Rules Governing Consultations

(1) Where a patient, in the opinion of his medical attendant, needs simple dental treatment, the patient should be referred in all but exceptional circumstances to his own dentist. In the event of the patient having no regular dentist, there is no objection to a doctor recommending a dentist of his own choice.

(2) Where a doctor (for the benefit of one of his patients), requires to consult a dentist, the doctor should communicate, in the first instance, with the patient's own dentist. In the event of the patient having no regular dentist there is no objection to the doctor consulting the dentist of his own choice.

(3) Where, for any reason, the patient's doctor considers that the patient should be sent to a dentist other than his own, or where a further dental opinion is sought, the patient's usual dentist should be informed.

NOTE.—Apart from a simple dental treatment, i.e., in the presence of a dental condition which might affect the general health of the patient or necessitate a major dental operation, the dentist should consult the patient's doctor before carrying out such treatment.

Anaesthetics

Where an anaesthetic is advised by the dentist, it is competent for him to select the anaesthetist, but if such anaesthetist is not the patient's doctor, no objection should be taken to the patient inviting his doctor to be present. Where the operation proposed is a major one, or if it is known to the dentist that the patient is under medical care, the dentist should consult the patient's doctor upon the operation proposed and should invite him to be present if the patient so desires. Similarly, where the patient is under dental care and the doctor advises operation or other major treatment arising from the patient's dental condition, the dentist should be consulted.

On the completion of any dental operation, and especially if there is any reason to think that post-operative complications may ensue, the patient should be advised to consult the dentist immediately if such complications arise and the dentist should take all reasonable steps to facilitate such consultation.

ORGANIZATION

Association Machinery

163. The Council has given further consideration to the Association's organization in relation to the National Health Service. It realizes that this may necessitate the calling of a special representative meeting at the appropriate time.

Conference of Honorary Secretaries

164. A successful conference of Honorary Secretaries of Divisions and Branches was held on April 22. A report of the proceedings appeared in the *Supplement* of May 3 (p. 93). It was decided that the Conference should in future meet at Headquarters and should be independent of the Annual Meeting.

THE ELDERLY AND INFIRM

(Continuation of para. 18 of Annual Report)

165. In view of the fact that the Regional Hospital Boards will shortly be planning the future hospital services, it has seemed advisable to arrange early publication of the main recommendations of the special committee which has been discussing an improved medical service for the aged. This committee has therefore expedited the completion of a report which the Council now submits in Appendix I under the title "Report (1947) of the Committee on the Care and Treatment of the Elderly and Infirm." The Council has authorized the publication of this report in pamphlet form and its distribution to Honorary Secretaries of Branches and Divisions in the United Kingdom, to Members of Parliament, to members of Regional Hospital Boards, to the Chairmen of Local Executive Councils, to the Clerks and the Chairmen of the Health Committees of the major Local Authorities, and to the Deans of Medical Schools. The Council has drawn the attention of the Negotiating Committee to the importance of securing co-ordination of the activities, in respect of the care and treatment of old people, of the different administrative authorities concerned.

MEDICAL FILMS

166. The Council appointed a special committee to inquire into the scope and use of films in postgraduate and undergraduate medical education. The committee's report, which was approved by the Council, appears in Appendix II.

In accordance with the committee's recommendations the Council proposes to establish a *Medical Film Bureau*, primarily to serve Divisions and Branches of the Association, and also to act as a central office to facilitate, co-ordinate, and assist in an advisory capacity the production of medical films in association with other bodies in this field. In addition the Bureau will (*a*) publish up-to-date information and answer questions relating to medical films; (*b*) arrange for the appraisal and grading of medical films; and (*c*) arrange film shows as requested.

The Council is also considering the establishment of a B.M.A. Film Library and a proposal that there should be a standing committee of the Association to manage the Medical Film Bureau and the Film Library, and to deal generally with matters concerning medical films.

INTERNATIONAL RELATIONS

War Crimes

167. At the International Medical Conference held at the B.M.A. Headquarters in London in September, 1946, delegates from the Continent spoke of the crimes committed by medical practitioners in their countries during the war. Appropriate action was called for in this connexion in the form of a statement and suggestion for a programme to prevent possible repetitions. The Council has accordingly prepared the following statement, which will be submitted to the General Assembly of the World Medical Association in September, 1947:

War Crimes and Medicine

The evidence given in the trials of medical war criminals has shocked the medical profession of the world. These trials have shown that the doctors who were guilty of these crimes against humanity lacked both the moral and professional conscience that is to be expected of members of this honourable profession. They departed from the traditional medical ethic which maintains the value and sanctity of every individual human being.

Crimes committed by doctors have been classified by the War Crimes Commission as follows:

(1) Experiments without consent on human subjects authorized by high authorities on the pretext of scientific research in the interest of the war.

(2) Experiments without consent conducted by medical officials in concentration camps on their own initiative in order to gain experience.

(3) Deliberate selection and killing of prisoners in camps by medical neglect or by lethal injections.

(4) Deliberate killing of infirm or feeble-minded patients and of children in hospitals and asylums.

From the above it is clear that doctors carried out their inhuman experiments both for the furtherance of the war effort and for research in disease. In the course of the experiments and in the application of their findings, they deliberately killed persons politically undesirable to the regime in power. They misused their medical knowledge and prostituted scientific research. They ignored the sanctity and importance of human life, exploiting human beings both as individuals and in the mass. They betrayed the trust society had placed in them as a profession.

The doctors who took part in these deeds did not become criminals in a moment. Their amoral methods were the result of training and conditioning to regard science as an instrument in the hands of the State to be applied in any way desired by its rulers. It is to be assumed that initially they did not realize that the ideas of those who held political power would lead to the denial of the fundamental values on which Medicine is based.

Whatever the causes such crimes must never be allowed to recur. Research in medicine as well as its practice must never be separated from eternal moral values. Doctors must be quick to point out to their fellow members of society the likely consequences of policies that degrade or deny fundamental human rights. The profession must be vigilant to observe and to combat developments which might again ensnare its members and debase the high purpose of its ideals. The medical crimes committed in the late war have shown only too convincingly how medical knowledge and progress unless governed by humanitarian motives may become the instruments of wanton destruction in the pursuit of war.

The influence of Medicine throughout a nation is often underestimated. Individually the doctor is more than the exponent of medical opinion and the technical expert. He is the confidant, the friend and the trusted adviser and wields an influence far beyond the immediate realm of physical needs. Collectively the medical profession can cultivate throughout the world the growth of international amity.

The following procedure by the World Medical Association is accordingly recommended:

(1) The publication of a resolution endorsing judicial action by which members of the medical profession who shared in war crimes are punished.

(2) The drafting of a World Charter of Medicine. This might take the form of a modern affirmation of the aims and ethics of Medicine in the spirit of the Hippocratic Oath, which should be published and applied in medical education and medical practice.

In medical education, the traditional aims and ethics of Medicine should pervade the curriculum. An undertaking to abide by these principles as expressed in a Charter of Medicine should be part of the medical graduation ceremony.

In medical practice, the adoption of this Charter by the World Medical Association and its constituent bodies and publicity through the world medical Press would do much to prevent a recurrence of such crimes and to ensure that Medicine remains a constructive and beneficent influence in society as a whole.

Appendix I

Summary of medical crimes, abstracted from reports of Nuremberg Trials, 1945–6

An abstract of the available evidence indicates that the so-called experiments include:

(*a*) The effect of vacuum and pressure chambers.

(*b*) Sterilization—chemical, operative, and radiological, with controls by artificial insemination.

(*c*) Blood transfusion.

(*d*) Cold water immersion, with periodic blood tests and different methods of resuscitation.

(*e*) Liver puncture.

(*f*) Deliberate septic infection.

(*g*) Excision of parts of the body.

(*h*) Experimental operative surgery—non-indicated operations—for instructional purposes.

(*i*) Exposure to gas and chemicals for varying periods and results checked by autopsy.

(*j*) Methods of "mercy killing," gas, benzene injections, cremation of semi-moribund individuals before death, etc.

Appendix II

Principles for inclusion in a Charter of Medicine

Aims.—The traditional aim of Medicine has been the succour of the bodily needs of the individual irrespective of class or race or creed, the cure of disease, the relief of suffering and the prolongation of human life. In later years the prevention of disease has been added to the traditional aim. All these have been accomplished by the scientific method coupled with the spirit of charity and service.

The achievement of the highest possible level of health for all people is an aim of the World Medical Association.

Ethics.—Although there have been many changes in Medicine, the spirit of the Hippocratic Oath cannot change and can be reaffirmed by the profession. It enjoins:

The brotherhood of medical men.

The motives of service for the good of patients.

The duty of curing, the greatest crime being co-operation in the destruction of life by murder, suicide and abortion.

Purity of living and honourable dealing.

Professional secrecy for the protection of patients.

Dissemination of medical knowledge and discovery for the benefit of mankind.

International Postgraduate Centre in London

168. The Council has considered the need for an international postgraduate centre in London to enhance the status of British medicine and to meet the demand of medical visitors from foreign countries as well as from the Dominions. Hopes have been expressed that a London centre might occupy, and even surpass, the place held by Vienna before the war. The Council has had the advantage of discussing the matter with Sir Francis Fraser, Director of the British Postgraduate Federation, who outlined the Federation's scheme for an international centre in London. Hitherto, most of the Federation's postgraduate facilities have been reserved for demobilized medical officers, but increased priority is now being given to doctors from the Dominions. Although there is a continuous stream of visitors from Europe, only a few can be accommodated by the Federation. With them, there arises the difficulty of registration; they cannot take hospital appointments, but can only attend courses.

The Council considers that for the moment the Association can best contribute to the welfare of these visitors by facilitating social contact. The aim should be to encourage them to call at B.M.A. House, where they would receive all possible help, and social occasions could be arranged where they could meet the officers of the Association and other distinguished British doctors. The Council therefore proposes, as a contribution to the development of international good will, to hold a reception twice a year for foreign medical visitors to this country, to enable them to meet representative members of the Association and other representatives of British medicine and to visit B.M.A. House.

World Medical Association

(Continuation of para. 113 of Annual Report)

169. The Council has appointed the following four representatives to attend the first Annual Meeting of the World Medical Association to be held in Paris in September, 1947.

Delegates: The Chairman of Council and Dr. J. A. Pridham.

Alternates: The President and Dr. E. A. Gregg.

NAVAL AND MILITARY

Indian Medical Service

(Para. 117 of Annual Report)

170. The Council has under consideration the White Paper on the terms of compensation for members of the Indian Medical Service. The scale of compensation proposed for officers of the Indian Medical Service is based on age and rises from £37 10s. for officers at 19 years of age to a sum of £6,000 for officers at 39 years, then progressively decreases to £375 at age 54—the highest age at which compensation is payable. It is announced that the Government of India accepts liability for pension and proportionate pension earned under the Secretary of State whether by civilians or by members of the Defence Services. British officers who accept appointment to another Crown Service on a permanent pensionable basis will receive, instead of cash compensation, a resettlement grant of £500. Those officers who are asked to serve on in India and decide to do so, but who subsequently decide that they wish to retire, will receive any compensation to which they are entitled. This will be determined, according to the published tables, by the date on which active service ceases, and service before and after June, 1948, will be taken into account.

Compensation will not be admissible to Indian officers except in those cases where officers are not invited to continue to serve under the Government in India after the transfer of power or can satisfy the Governor-General that their actions in the course of duty have damaged their prospects and that they have legitimate cause for anxiety about their future.

Qualification Standards for Service Specialists

171. The Council has made suggestions to the Medical Departments of the R.N. and R.A.F. based on the following arrangements already in force for the training of specialists for the Regular Army:

(1) Early selection of suitable officers, as trainees.

(2) Training under experienced specialists during the early years of service.

(3) Senior officers' course in general subjects of 5 months' duration.

(4) Selection for final training as specialists.

(5) Up to 12 months solely devoted to training at a suitable teaching school with appointment in that school where possible. At this stage higher qualification should be obtained.

(6) Examination by board of examiners including external examiners.

(7) Approval by the Royal Army Medical College Council.

(8) Refresher courses up to 3 months at suitable teaching school approximately every 3 years.

(9) Supervision of all specialists relative to their continued employment by Royal Army Medical College Council.

Particular importance is attached to the implementation of items 5 and 8 of this policy.

Post-war Code of Pay—Officers' Marriage Allowance

172. An announcement has been made that officers of the three Services who marry before reaching the qualifying age of 25 years for recognition as married officers for service purposes shall be eligible for a modified rate of marriage allowance of 45s. per week until they attain that age and qualify for the higher rates, which are approximately twice as favourable. Information is being sought by the Council as to the reasons for granting a lower rate of marriage allowance to these officers.

SCOTLAND

Interim Increase in Salaries of Medical Officers of Health

(Continuation of para. 123 of Annual Report)

173. The meeting with representatives of the Associations of Local Authorities in Scotland has now been held, but it has not been possible to secure the adoption of an agreed scale in respect of the salaries of whole-time members of the Public Health Service in Scotland similar to that which obtains in England under the Askwith Memorandum. The contention of the Local Authority Associations is that in the large majority of cases Medical Officers of Health in Scotland are receiving remuneration comparable with, and in some cases superior to, that which would be paid under the revised Askwith Memorandum and that there should be a direct approach, on behalf of the Association, to any authorities which are not paying salaries in accordance with the revised scale. They have indicated that they would be prepared to recommend to the authorities in such instances that immediate consideration should be given to any case of injustice or inequity.

Information regarding the salaries of members of the whole-time public health medical service in Scotland is being collected, and further action has been deferred pending the result of this inquiry.

National Health Service (Scotland) Act

174. The Scottish Bill has now completed its passage through Parliament and received the Royal Assent. During the passage of the Bill through the House of Lords a number of amendments acceptable to the profession were secured.

In its main provisions the Scottish Act is similar to that for England and Wales; the chief variations are:

(1) No differentiation is made in the administration of teaching and non-teaching hospitals. The profession as a whole, in Scotland, considers that this arrangement is more appropriate to Scottish conditions, as the teaching hospitals in Scotland are regional in character and for this reason should not be divorced from the Regional Boards.

(2) The appointment of a Hospital Endowments Commission which has the duty of reviewing all endowments and making schemes for their future management and application.

With a view to negotiations with the Secretary of State on the regulations and orders to be made under the Scottish Act, the Scottish Negotiating Committee has been enlarged and reconstituted on lines similar to the English Negotiating Committee. Action is being taken through the Branches and Divisions in Scotland for the preparation of lists of practitioners which can be submitted to the Secretary of State as suitable for appointment to Regional Hospital Boards. Action is also being taken through the Association machinery in connexion with the constitution of Local Medical Committees in Executive Council areas.

Liaison Committee with Scottish Branch of the Royal College of Nursing

(Continuation of para. 128 of Annual Report)

175. This Committee is considering problems of the nursing profession, its future status and development, and the means by which the medical profession can assist in the solution of these problems.

Liaison Committee with Scottish Branch B.H.A.

176. A Liaison Committee with the Scottish Branch of the British Hospitals Association has been established and is discussing matters of mutual interest arising in connexion with the new National Health Service.

Reorganization of the Association in Scotland

177. The establishment in Scotland of a permanent organization on a regional basis representative of the whole profession, and the reorganization of the Association in Scotland in response to the changes in medical administration resulting from the new Health Service, are being considered.

WALES

178. The Council has informed the Ministry of Health that, in the view of the Association's Welsh Committee, the proposed medical membership of the Regional Hospital Board for Wales is in substantial part unrepresentative of medical opinion in Wales, with the result that the Board will not command the confidence of the profession. The Department has been asked for its comments.

CO-OPERATION WITH DOMINIONS

179. The Council, believing that there is a widely felt desire for a closer liaison between the profession in Great Britain and the Dominions, set up a special committee, of which the President, Sir Hugh Lett, was appointed chairman, to consider ways and means by which more effective steps might be taken to deal with matters of common interest affecting practitioners in this country and in the Dominions.

There is a Standing Committee appointed to deal with questions relating to Overseas Branches, but this Committee is concerned almost entirely with questions regarding the terms and conditions of service in the Colonial Medical Service. The Council recognizes the value of the work done by the Dominions Committee, and considers it important that there should continue to be a channel by which members serving in the Government Services overseas should be enabled to receive the support of the Association in efforts to secure improved conditions of service. The present Dominions Committee, however, does not deal with matters affecting the Dominions, nor in the view of the Council is it so constituted as to be able to develop and maintain a close liaison with the profession in the Dominions.

In the Council's view the need for closer contact between the profession in Great Britain and the Dominions can be met only by special machinery providing for active representation from the Dominions. The Council proposes, therefore, to invite the Canadian Medical Association, the Federal Council of the Association in Australia, the New Zealand Branch, the South African Medical Association, the Medical Association in Eire, the Newfoundland Medical Association, and the Branches in Southern Rhodesia to co-operate in the establishment of a special Council to be called "The British Commonwealth Medical Council" on which the professional bodies mentioned above should appoint their own representatives, and which should meet at least once a year to discuss problems of common interest and to exchange views. Such a body, it is felt, would be most effective in establishing a real link between the profession in this country and the Dominions, and under present conditions of travel would be a practical possibility. In the view of the Council it would be practicable, and indeed desirable, that the Commonwealth Council should meet in various parts of the Empire, but it is felt that this is a matter which might well be left to the Commonwealth Council itself.

180. The Council has also considered what action might be taken by the Association to assist members of the profession coming to this country from the Dominions and Colonies for postgraduate or other purposes. Particularly at the present time, overseas members find considerable difficulty not only in making satisfactory arrangements for postgraduate work, but also in such matters as accommodation and contact with their British colleagues. London House, the Victoria League, the Fellowship of Medicine, and other bodies are already doing admirable work in helping undergraduates and postgraduates, but much remains to be done, and co-ordination is desirable. This could be achieved by the establishment of a central bureau where all overseas members would be welcomed on their arrival in this country, and where they could obtain general information and advice. The Council proposes, therefore, to establish such a Bureau, to be called "The Empire Medical Advisory Bureau."

MEDICAL BENEVOLENCE

181. The sum of £7,348 was received during 1946 by the Charities Trust Fund of the Association for medical charities, as compared with £7,160 for 1945 and £6,876 for 1944. This continued increase is gratifying and the Council hopes that the total for 1947 will show a further increase and so assist the charities to meet the increasing demands on their funds.

H. GUY DAIN,
Chairman.

APPENDIX I

REPORT (1947) OF THE COMMITTEE ON THE CARE AND TREATMENT OF THE ELDERLY AND INFIRM

I. PRELIMINARY

1. In July, 1946, the Representative Body of the British Medical Association adopted the following resolution:

> "That this meeting is of the opinion that inadequate provision is at present made for the treatment and care of the elderly and/or infirm, and instructs the Council to set up a Committee to investigate the whole position and report."

2. In accordance with this instruction the Council appointed a special Committee at its meeting on Nov. 6, 1946. The following are the members of the Committee:

Janet K. Aitken, M.D., F.R.C.P., London.
Lord Amulree, M.A., M.D., F.R.C.P., London.
A. Greig Anderson, M.A., M.D., F.R.C.P., Aberdeen.
E. B. Brooke, M.A., M.B., M.R.C.P., D.P.H., Carshalton.
Sir Ernest Rock Carling, M.B., F.R.C.S., F.R.C.P., London.
L. Z. Cosin, F.R.C.S., L.R.C.P., Orsett.
Miss E. M. Crothers, London. (Nominated by the Queen's Institute of District Nursing.)
Mary Esslemont, M.A., B.Sc., M.B., Ch.B., D.P.H., Aberdeen.
J. Fenton, C.B.E., M.D., M.R.C.P., D.P.H., London. (Chairman, Public Health Committee.)
R. G. Gordon, D.Sc., M.D., F.R.C.P.Ed., Bath.
T. Anthony Green, M.B., F.R.C.S., D.M.R.E., London.
E. Guttmann, M.D.(Munich), M.R.C.P., London.
Alderman Mrs. M. M. C. Kemball, Eccles. (Nominated by the National Old People's Welfare Committee.)
G. MacFeat, O.B.E., M.B., C.M., Douglas, Lanarkshire.
Miss C. Morris, London. (Nominated by the Institute of Almoners.)
R. L. Newell, M.D., F.R.C.S., Manchester. (Chairman, Hospitals Committee.)
A. T. Rogers, M.B., B.S., Bromley.
W. D. Steel, M.B., B.S., Worcester.
F. R. Sturridge, *M.C.*, M.R.C.S., L.R.C.P., London.
S. Wand, M.B., Ch.B., Birmingham. (Chairman, General Practice Committee.)
Marjory Warren, M.R.C.S., L.R.C.P., London.

The Committee appointed Dr. A. Greig Anderson as its Chairman and Dr. Janet K. Aitken as Deputy Chairman.

3. The Committee has received a considerable amount of information regarding the provision made at present by various public authorities and voluntary organizations for the housing and general welfare of the elderly and infirm; and it has studied the findings and recommendations of a number of earlier investigators of these matters, notably those contained in the admirable report on "Old People" drawn up by a Survey Committee of the Nuffield Foundation under the chairmanship of S. Seebohm Rowntree and published early in 1947. The Committee cannot better summarize the present position than by quoting a paragraph from an article by one of its members which appeared in *The Times* of Nov. 25, 1946: "Britain still lacks a systematic policy for the welfare of the elderly. The elements of such a policy are, however, now becoming fairly well understood. The new retirement pensions, the welfare work of the Assistance Board and the voluntary societies, the growth of home help schemes, the extension of social clubs for the elderly and of local old people's welfare committees, the rapidly rising public interest in the housing of the elderly and, though much less marked, in encouraging elderly people to remain in employment—all these developments are welcome indications

of an awakening social conscience. But they have focused attention principally upon the more fortunate among the elderly —those who are fit enough to lead fairly normal lives. There is as yet no commensurate awareness of the plight of the infirm, the decrepit, the incapacitated, the sufferers from long-lasting ill-health or recrudescent disease, and the permanently incurable. For most of these, concealed from the public eye in institutions, no services are yet provided which in any way meet their needs or their deserts."

4. The Committee has therefore thought that its own distinctive contribution might best take the form of a discussion of the arrangements desirable for the better investigation and treatment of physical and mental disability and disease among old people. Section II of this report explains the classification of the elderly adopted by the Committee and outlines briefly the main conclusions of the Committee regarding the special needs of the various groups. Section III deals in greater detail with the housing of the elderly, and in Section IV the Committee submits a full account of its proposals for a co-ordinated medical service for old people, based on special "geriatric" departments in selected general hospitals.

5. In the preparation of Section IV the Committee has received valuable assistance from three of its members—Dr. Brooke, Mr. Cosin, and Dr. Warren—who have long experience of the aged sick. Indeed, this section is based on a draft which was written by them, primarily with a view to publication in the medical press, and which, somewhat modified in the light of the Committee's discussions, is likely to appear in print (with the full concurrence of the Committee) in advance of this report. Section IV represents the considered views of the Committee as a whole, but in the formulation and exposition of its views the Committee has been greatly helped by these three members, and acknowledges with gratitude its indebtedness to them. The diagram illustrating this part of the report is the work of another member, Mr. T. Anthony Green, to whom also special thanks are due.

II. CLASSIFICATION OF THE ELDERLY

6. To facilitate consideration of the varying needs of old people in health and sickness, the Committee began its work by classifying persons above the age of 60 in the following categories: (1) The elderly. (2) The elderly and infirm. (3) The elderly sick: (*a*) acute sick; (*b*) long-term sick (potentially remediable); (*c*) irremediable. (4) Elderly psychiatric patients:—(*a*) Those not requiring mental hospital treatment: (i) those who can stay in their own homes; (ii) those needing custodial care in a long-stay annexe. (*b*) Those in need of active psychiatric care or treatment in a mental hospital. (5) Other special groups.

7. *The Elderly.*—Category (1) comprises those elderly people who are sufficiently healthy and active to manage small homes of their own. The field surveys carried out by the Nuffield Committee showed that some 95% of old people live in private dwellings. A high proportion of these old people, including a considerable number who are really unfit to do so, lead independent lives. For those who are physically and mentally capable of living independently what is chiefly needed is a more ample provision of houses and flats suitably situated and of appropriate size and design. The problem here is one of accommodation rather than of medical care. No special arrangements for medical supervision are necessary, though from time to time the services of the district nurse would be of great value. In occasional illness these people, like other members of the community, will be under the care of the general medical practitioners of their choice, through whom they will obtain the services of consultants and specialists when required. When, however, they become chronically ill, or too infirm to continue living in their own homes, it should be the responsibility of the special hospital department for old people—the geriatric department described in Section IV of this report—to advise as to suitable arrangements for their care or treatment. The housing of old people is considered in some detail in Section III below. The Committee thinks it important that the relatively able-bodied elderly should not be segregated from the rest of the community but that separate accommodation, specially designed for them, should be included in general housing schemes.

8. *The Elderly and Infirm.*—In Category (2) are those elderly people who suffer from the disabilities of age but not from extreme frailty or from chronic disease. Their need is for admission, under the guidance of the geriatric department, to suitable homes or hostels providing domestic care rather than continuous medical or nursing attention. Such homes exist at present, but by no means in sufficient numbers. Some are administered on a semi-charitable basis by voluntary societies or local authorities, while others are conducted for profit by private individuals. The Committee is in full sympathy with the recommendation of the Nuffield Committee that establishments of the latter type should be brought under supervision through a system of statutory inspection of voluntary homes if this is found to be practicable.

9. The medical care of residents suffering from minor illness of short duration is best undertaken by the general practitioner; and the staff of the home should include a person trained in the nursing of the aged, who may be a State-registered nurse, an assistant nurse, or even a part-time nurse. Any resident who becomes a victim of a more serious acute illness or of a chronic complaint should be transferred to hospital; and readmission to the home on discharge from hospital should be arranged in consultation with the geriatric department of the key or district hospital. This supervision by the geriatric department is essential if the home is to fulfil its proper function of caring for old people who are infirm but not ill. The Committee believes that, as a result of the establishment of such departments, many old people who under present conditions might be labelled as "chronic sick" without adequate investigation will be rehabilitated and enabled to lead comparatively normal lives in homes providing only domestic care. When a "two-way traffic" has been established between the home and the hospital the reluctance of old people to go to hospital is likely to be overcome, as they will have no reason to fear that removal to hospital inevitably means leaving home for ever. The equipment and general management of residential homes are discussed briefly in Section III.

10. *The Elderly Sick.*—Category (3) includes three classes of old people who are ill and not merely infirm. The acute sick, as has been stated above, should be transferred to hospital for treatment unless their complaints are of a comparatively trivial nature, and they should have the advantage of rehabilitation facilities specially provided for old people in the geriatric department. But it is for the long-term sick and those suffering from incurable disease that greatly improved arrangements are most urgently required. Commenting on the disclosures made in the reports of the regional hospital surveys carried out for the Ministry of Health, the Council of the Association wrote as follows in its annual report to the Representative Body in 1946: "The survey reports make it clear that—to quote from one of them—'in general the care of the chronic sick requires complete and revolutionary change.' These patients are often accommodated in antiquated and unsuitable buildings originally designed for other purposes. The arrangements for their medical and nursing care, and for the provision of occupational and recreational facilities, leave much to be desired. There is great need for better classification of patients and, in particular, for making separate provision for the elderly and infirm, for the incurable, and for those who, with proper medical care, may be returned to normal living conditions. Perhaps the most urgently needed reform is the arrangement of a full diagnostic investigation of these cases before they are classified as 'chronic.' In the opinion of the Council, such patients should pass through acute general hospitals before being referred to special institutions, and a proportion of them should be retained in the general hospitals for treatment. This is desirable not only in the interests of the patients but also in the interests of the education of medical students and of student nurses."

11. The solution of the problem which the Committee favours is the gradual establishment in selected general hospitals, including teaching hospitals, of special geriatric departments, the proposed functions of which are described in detail in Section IV. The consultant in charge of such a department would be available to advise on the condition of any elderly patient in the hospital, and in suitable cases patients would be admitted or transferred to the geriatric wards for observation, treatment, or rehabilitation. It would be the special

responsibility of the geriatric department to assess, in consultation with other members of the hospital staff, the prospects of recovery of the long-term sick, and to arrange the resettlement of patients leaving hospital and unfit to live in their own homes. Those considered irremediable would be admitted to long-stay annexes, closely associated with the hospital. Here they would remain under the supervision of the geriatric medical team, who would arrange readmission to the hospital should reason be found to consider further expert investigation or treatment likely to be of advantage. Those patients who on discharge from hospital were judged suitable for admission to residential homes would be allocated to suitable homes with the assistance of almoners and social workers attached to the geriatric department, the homes being selected with due regard to the habitual domicile of the patients and the arrangements being facilitated by an administrative liaison between the regional hospital board and the local authorities. The rehabilitation facilities of the department would be available for elderly out-patients, and special transport arrangements would be organized for the conveyance to and from the hospital of old people likely to benefit from group exercises and other forms of physiotherapy. Finally, the geriatric department would carry out research into the process of ageing and would take part in the training of medical students and nurses. There would no doubt be a much-needed advancement of knowledge concerning the diseases of the ageing and the aged through research conducted in departments of the kind proposed, which could command the full laboratory services and other special resources of the larger general hospitals.

12. *Elderly Psychiatric Patients.*—Category (4) may be regarded as a subsection of Category (3), but old people suffering from mental disease or infirmity are included as a separate group in the Committee's classification in view of the importance of special provision being made for their care or treatment apart from other patients. For this group, which contains many senile dements but also elderly patients suffering from other forms of mental disorder, the observation wards of the geriatric department should be used as a clearing-house, and only after expert assessment by a psychiatric consultant in this department should a patient be sent to a long-stay annexe as irremediable or to a mental hospital as likely to benefit from the active treatment provided in modern hospitals of this kind. The Committee is strongly of the opinion that cases of simple senile dementia should be regarded in a different light from other cases of mental disorder and that it should be made unnecessary for any such patient to be certified. When senile dements are likely to remain docile and manageable as a result of care and treatment, they should be accommodated, so far as may be practicable, outside the mental hospitals. It is distressing to the relatives, and it may be prejudicial to their interests, to have to disclose, as is necessary in connexion with various transactions, that a member of the family has been certified as insane or even that he has been admitted to a mental hospital: and the Committee considers it unreasonable that cause should be given for such distress when the member in question is merely a victim of mental deterioration associated with old age. There is much need for research into mental abnormality in the aged, and this would be greatly facilitated by the admission of elderly psychiatric patients to special wards in geriatric departments of the kind here contemplated.

13. *Other Special Groups.*—Category (5) includes various other groups of elderly patients for whom special provision is desirable, such as the blind and the deaf. For the latter group such provision is practically non-existent at the present time.

14. If the needs of the various groups of old people, as indicated briefly above, are to be met satisfactorily, it is essential that arrangements should be devised for co-ordinating the activities of the four different administrative authorities concerned. (1) The regional hospital board will be responsible for providing medical treatment and nursing care in hospitals and related institutions, and consultant services at the hospital and in the patient's home. (2) The general medical practitioners attending old people in their own homes or in hostels will work in a service administered by local executive councils established in the areas of the major local authorities. (3) The local authorities themselves will be concerned with housing, including the provision of residential homes for the elderly and infirm, and also with home help and home nursing services. (4) Finally, the responsibility for the care of the aged will be shared by a new body to be set up by legislation now proposed for the purpose of replacing the Poor Law. How, then, can the work of these four authorities be co-ordinated? For example, how can it be assured that the general practitioner wishing to arrange accommodation for an elderly and infirm patient in a residential home, or institutional care and treatment for an old person mentally afflicted, will refer the patient in the first instance to the geriatric department of the hospital for expert investigation and appropriate allocation? Or that the residential homes, both local authority and voluntary, will admit only persons considered suitable by the geriatric medical staff, and will retain them only so long as they continue to be suitably housed in these establishments? Or that the local authorities will maintain a sufficient number of residential homes, additional to those provided by voluntary societies, to permit of vacancies being found promptly for old people ready to be discharged from hospital and recommended for this type of accommodation? Or that the hospitals will admit with equal promptness elderly patients from residential homes, or from private dwellings, whose condition has become such as to demand immediate investigation or treatment? The problem, although partly one of bricks and mortar, will not be solved merely by the supply of sufficient buildings, suitably equipped and staffed. The scheme may well fail unless, through the establishment of standing liaison committees, means are found to bring about such close co-ordination of the functions of the various authorities as will ensure the free passage of elderly people, under the expert guidance of the geriatric department, from home to hospital and from hospital to home in accordance with their changing needs. It is to be hoped that those organizations which make provision for the aged but are not under public control will consent to play their part in a co-ordinated service, for the plan cannot be operated without the willing collaboration of all the agencies concerned, both public and voluntary.

III. HOUSING THE ELDERLY

15. Among students of the subject there appears to be a large measure of agreement as to the location, design, and equipment of dwellings for old people and the general manner of conducting residential establishments for the elderly. The Committee has not made an exhaustive examination of these matters, but it may be useful to include here a short statement of certain considerations which it regards as important, even if this amounts to little more than an endorsement of some of the recommendations already made in other publications.

16. In the preparation of new housing schemes provision should be made for persons of all age groups, and the able-bodied elderly should not be segregated from the rest of the community. Many of the elderly enjoy association with their juniors, especially with children; and younger neighbours are of much assistance to them, particularly during times of sickness, and often receive useful services in return. There are advantages, however, in housing the elderly in a particular part of a housing area or block of flats, as this facilitates the provision of background heating and communal meals, as well as home help, nursing, and visiting arrangements. At an early stage of its deliberations the Committee addressed a communication to the Ministry of Health in which it recommended that the Ministry should ensure that new housing schemes of local authorities made special provision for the accommodation of old people in conformity with this policy of "separation without segregation."

17. Houses for the elderly and residential homes for groups of old people should be situated, whenever possible, in the districts in which the residents have previously lived, so that they may be able to keep in touch with their friends. The sites chosen should be conveniently near to churches, shops, and places of entertainment. Dwellings for the able-bodied elderly may take the form of single-storey cottages or bungalows, or two-storey houses divided into flats. Accommodation provided in a block of flats should not be higher than the first floor unless a lift is installed. For old people occupying a group of self-contained dwellings some communal facilities are

desirable. These should include a lounge and a dining-room where a hot midday meal may be obtained.

18. The size of the dwelling may vary in accordance with individual requirements. For a single person or an aged couple it is sufficient as a rule to provide a living-room, a bedroom—or, as the Committee considers preferable, a ventilated "bed-recess" or bedroom-annexe—a kitchen-scullery, and a bathroom with w.c. The bedroom-annexe, opening off the living-room and separated by a curtain or partition by day, is recommended for the sake of greater warmth. If it is sufficiently spacious and well ventilated there can be no objection to it on the ground of hygiene. A good example of the bedroom-annexe with its own window has been provided in the Crookston Home, maintained by the Corporation of Glasgow. A further essential provision is indoor storage space for fuel. A number of plans of dwellings specially designed for the elderly are included in the *Housing Manual* of the Ministry of Health and Ministry of Works, in *Old People's Welfare*, published for the National Old People's Welfare Committee by the National Council of Social Service, and in *Housing the Old*, by Olive Matthews.

19. For those old people who are incapable of managing small homes of their own the residential home of the hostel type is suitable. It is generally agreed that such a home should be comparatively small, accommodating not more than 30 to 40 residents, so that the atmosphere may be homelike rather than institutional. It should preferably admit elderly people of both sexes and contain double bedrooms for married couples. In converted houses in which it is impracticable to construct small single bedrooms a measure of privacy may be secured by the provision of curtained cubicles. There should be central heating, supplemented by open fires in the sitting-rooms. Handrails should be provided on both sides of staircases and passages, and hand supports at the sides of baths. Some of the baths should be partially sunk and should stand clear of the walls so that assistance in rising may be given from both sides to the more infirm residents.

20. Hostels of this kind should be made as comfortable and homely as possible by suitable furnishing and attractive decoration. But the provision of the right physical environment is not enough. Old people have been known to become indolent and apathetic in luxuriously comfortable surroundings. The elderly like to feel that there is something useful that they can do, and it is important that they should have opportunities of occupation suited to their physical capacity. The women should be encouraged to assist in various household tasks and the energies of the men may find a suitable outlet in the lighter gardening operations or in light constructional work in accordance with their previous trades or hobbies. It would be of advantage if, through the liaison that should be established between the geriatric department of the hospital and the residential homes, the benefits of occupational therapy could be made available in these homes to elderly people in need of such treatment. The provision for recreation should include indoor games and entertainments, suitable radio facilities, and a supply of books from the local public library.

21. The atmosphere of the home will be greatly influenced by the attitude of the resident staff and especially of the warden, who should be chosen with great care. As is stated in the booklet, *Hostels for Old People*, issued by the Friends' Relief Service, "nothing but genuine personal friendship will make possible the natural building up of the community on a co-operative and homelike basis." The greatest possible personal freedom should be allowed to the residents, and there should be no unnecessary regulations. The Committee has noted with satisfaction the recommendations made on this subject in a circular* recently issued by the Ministry of Health to local authorities administering old people's homes. The authorities are encouraged, for example, to permit the residents to come and go as they please (signing out to indicate where they are going), to receive visitors on any day of the week, and to provide and use their own clothes (for the custody of which a wardrobe, a chest of drawers, or at least a locker with keys should be provided). The Committee would add that there should be no ban on the reception of children as visitors.

* Circular 49/47.

Another matter to which the Committee attaches importance is the encouragement of independence in the old people by their being allowed to handle their own pensions, from which they will pay towards the cost of their maintenance, retaining a reasonable amount as pocket-money.

22. The Committee wishes to draw attention to the desirability of improving the supply of liquid milk to old people. It considers that, if practicable, arrangements should be made to provide all persons above the age of 70 with at least one half-pint of liquid milk daily, and preferably not less than one pint daily.

23. Finally, the Committee wishes to emphasize the value of welfare work among old people such as is carried out by the National Old People's Welfare Committee, on which more than thirty independent voluntary societies are represented. This work includes, for instance, the visiting of elderly people in their own homes and in institutions and the organization of social clubs for the elderly, voluntary home help schemes, and communal meals services. There are many ways in which suitably chosen home visitors may be of great assistance to the elderly, especially to those who are friendless and lonely. They may help by undertaking shopping, by explaining rationing problems, by changing books at the public library, by arranging the provision of spectacles, by giving introductions to local working parties or social clubs, and so on. In the past the Brabazon Employment Society has rendered valuable service by supplying both materials and voluntary helpers to enable old people in institutions to occupy their time in needlework and handicrafts of various kinds; and a one-day course of instruction has been established by the Community Council of Lancashire for persons willing to help elderly people to do simple handwork. Many other examples of practical work for the welfare of the aged are to be found in the excellent booklet entitled *Old People's Welfare*, to which reference has been made in paragraph 18 above. It may be hoped that, as a result of the growing awareness of the needs of old people, the voluntary societies will be able to extend considerably their most useful and commendable activities in this field.

IV. A CO-ORDINATED MEDICAL SERVICE FOR THE ELDERLY

24. The medical care of the elderly sick (over 60 years of age) and of the infirm has for a long time been unsatisfactory, but now conditions have so far deteriorated as to call for immediate action. The problem is largely numerical, as is shown by the following tables, taken from the reports of the Registrar-General.

TABLE I.—*Great Britain—Numbers Aged 60 or over*

Year	Men	Women	Total
1901	1,071,519	1,336,907	2,408,426
1939	2,511,200	3,197,400	5,708,600
1944	2,737,000	3,590,000	6,327,000
1946	2,828,000	3,759,000	6,587,000

TABLE II.—*Great Britain—Expectation of Life*

Year	Men	Women
1891–1900	44·1 years	47·8 years
1901–1910	48·5 „	52·4 „
1942	61·7 „	67·4 „

It will be seen that the increased expectation of life resulting from advances in industrial welfare, preventive medicine, housing, nutrition, and in the general standard of living has produced a greatly increased and increasing population in the higher age groups. In the Beveridge Report it is estimated that the number of old people (men over 65, women over 60 years) will have risen from 5,571,000 in 1941 to 9,576,000 in 1971. These figures are arresting, and their implications must receive the closest consideration in future hospital planning.

25. There will be general acceptance of the statement that the morbidity rate rises steeply with advancing years, and this

is well illustrated by the table below, which was published in *Annals of Surgery* (U.S.A.) of June, 1946.

TABLE III.—*United States of America*

Ages	Invalids per 1,000
All ages	11
65–74	53·5
75–84	72·7
Above 85	106·2

It follows that in the future, with an ageing population, there must be a rapid increase in the number of aged sick. Moreover, in the last decade this feature has been accentuated by the success of chemotherapy in the treatment of respiratory disease, which has hitherto been one of the prime causes of death in elderly folk. It may therefore be anticipated that, with the increased use of penicillin and the sulphonamides, the common causes of serious physical illness in old people (other than trauma and surgical conditions) will be cardiac and cerebro-vascular diseases and those in the rheumatic group. To these must be added the psychiatric conditions encountered amongst the elderly.

26. In the past, many of these elderly patients have found their way into institutions and hospitals for the chronic sick, where in some cases, with but few facilities for rehabilitation and in an atmosphere of defeatism, they have been treated by little more than recumbency. The results of this lack of treatment are all too well known to those who have had experience of such conditions. When confined to bed for long periods these patients soon drift into the "infirmary decubitus" with its avoidable contractures and deformities. In such positions they become fixed and immobile and often unable to feed themselves. The muscles of the back and abdomen become atonic from disuse-atrophy, so that even sitting up in bed is difficult and often impossible. Subsequently for many the only movement of the body is during the frequent nursing changes necessitated by incontinence and for the prevention of bed-sores. Under such conditions the patient soon sinks into apathy and, having lost hope of recovery, grows fretful, irritable, and morose. This atmosphere of hopelessness is shared by staff and patients alike, for the latter are equally aware that life now offers them no more than slow deterioration under regular nursing attention.

27. This preventable tragedy does not end here, for these unfortunate patients in their growing numbers must, if inadequately treated, rapidly diminish the available hospital beds of all types. Moreover, as a result of this slowing of the in-patient turnover, out-patients awaiting admission to hospital will in future have an even longer wait than at present. This state of affairs leads to a waseful use of nurses, and there can be no doubt that it will tend to hamper recruitment to an already depleted profession. Without reform there is a grave likelihood that hospital services throughout the country, already severely handicapped by a shortage of beds due to insufficient nurses, will be still further crippled.

28. Much can be done at once towards the solution of these closely interrelated problems by a co-ordinated medical service for the elderly in each Region, with the establishment of geriatric departments based on selected general hospitals, including teaching hospitals. The accompanying diagram illustrates the co-ordinated geriatric service. This is a new concept, the structure of which calls for further elaboration. Its framework is composed of three interdependent sections: (1) the geriatric department; (2) long-stay annexes; (3) residential homes.

29. *Definitions.*—A geriatric department comprises wards in a general hospital reserved exclusively for elderly patients, all of whom are undergoing investigation or active treatment and rehabilitation so that in due course they may be discharged from such wards, either to their own homes or, after classification, to other appropriate accommodation.

Long-stay annexes provide, under the medical supervision of the geriatric department, *accommodation and nursing care* for irremediable elderly patients who, after full investigation and treatment in the geriatric department, show no promise of further improvement.

Residential homes provide, in close association with the geriatric department, accommodation for 20 to 40 elderly persons in need of reception but *not of nursing care.*

30. *The Geriatric Department.*—In view of the ageing population it is essential that in selected general hospitals of the future, including teaching hospitals, there should be geriatric departments for investigation and treatment of elderly patients, *whether acute or chronic,* in respect of their senescence. Geriatricians do not claim competence to treat all those pathological conditions which at other periods of life call for the skill, exceptional experience, and technique of all the specialists. They do maintain that, in so far as diseases are modified or complicated by the consequences of senescence and demand modifications of general care, they should be consulted; and that they should be given the status, the beds, and the executive authority which will permit them to function in the prevention of avoidable invalidism, in minimizing waste of man-power, in the conservation of nursing resources, and in the elimination of waiting-lists for beds.

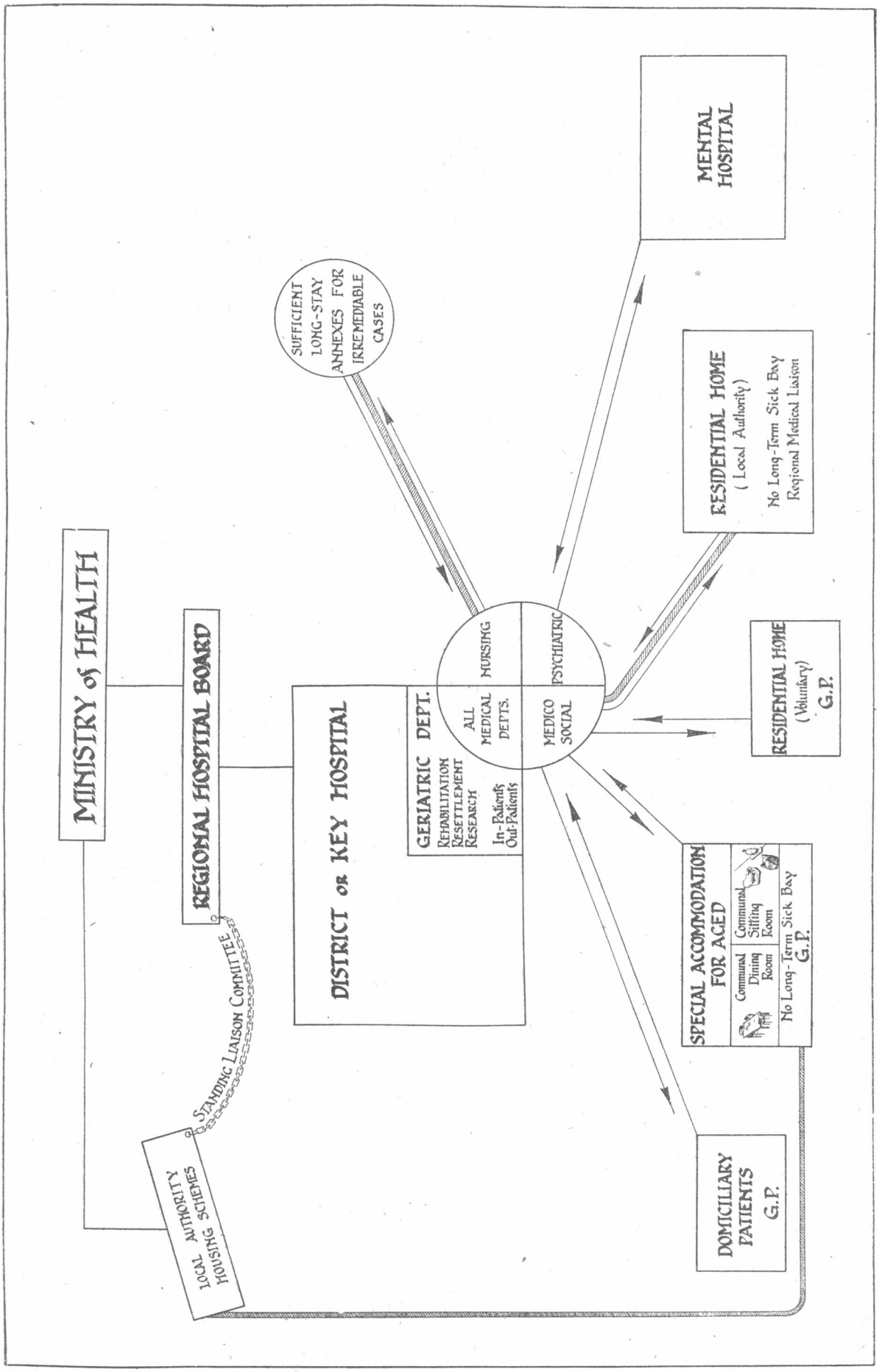
31. Over a given period of time (say a year) a proportion of all new admissions to such a department will have become fit for discharge, others will have died, and the remainder will constitute a residuum of patients from whom no further response to treatment can be expected. This residuum will require permanent nursing care. To avoid blocking hospital beds, all such long-stay patients should be transferred to long-stay annexes *under the same geriatric administration,* a steady admission rate to the geriatric department itself thus being maintained. Certain members of the Committee who have long experience in the care of the elderly sick estimate that each year some 40% of all new geriatric admissions would be discharged from hospital and that probably 40% would die, leaving a residual 20% of patients who, after failure to respond to full and prolonged treatment, would require permanent nursing care. An analysis of cases treated over a two-year period by one of these members leads him to regard this estimate of 20% as too high.

32. From an analysis of elderly psychiatric patients (over 60 years of age) admitted to Netherne Mental Hospital, Cunningham Dax reports (in a personal communication to a member of the Committee) that his discharges and deaths over a recent two-year period were each approximately 40% of such patients admitted. Of these discharges and deaths about 80% occurred within six months of admission. Arguing from these figures, he advocates that there should be an observation section attached to the general hospital's geriatric department. All elderly psychiatric patients would in the first instance be admitted there, and only those proving unsuitable would be transferred to the mental hospital. This arrangement would deal with about 80% of all such patients, a large number of whom need never enter a mental hospital at all. The "20% residuum" of patients would be transferred to appropriate long-stay annexes when their condition appeared to be stationary. The Committee is strongly in favour of this plan. In particular, it thinks it most desirable, for reasons which have been stated in paragraph 12 above, that the care or treatment of senile dements should be arranged, so far as possible, outside the mental hospitals.

33. It is not proposed to suggest what should be the size of any geriatric department, but clearly the number of hospital beds occupied by patients over 60 will form a considerable and growing proportion of the whole. In the future a larger percentage of all admissions will be drawn from patients in the higher age groups. Some of these elderly patients will obtain direct admission to the geriatric department, and a number of others may be transferred to it from other wards for rehabilitation and resettlement, for it is hoped that this department will be able to absorb older patients from the acute medical wards and also to relieve the surgical wards of their elderly patients after the post-operative phase. In conjunction with the beds in the geriatric department within the general hospital there must be sufficient beds conveniently situated in long-stay annexes to meet the needs of the "20% residuum" which will be transferred to them from time to time. It is important that plans for the care and treatment of the elderly sick should be drawn up in accordance with a long-term policy related to probable future requirements and not merely to immediate needs.

34. The following is a summary of the functions which a geriatric department should perform in consultation with other

DIAGRAM OF A GERIATRIC SERVICE



hospital departments: (1) To accept new geriatric patients whether acute or chronic, and those transferred from other wards. (2) To provide facilities for the investigation and treatment of geriatric patients. (3) To provide observation wards for the primary investigation of all elderly psychiatric patients and the medical treatment of such patients in suitable cases. (4) To afford earlier rehabilitation of the elderly by more adequate and prolonged use of physiotherapy and occupational therapy. (5) To discharge all rehabilitated patients from its wards, and to resettle them, where necessary, in residential homes. (6) To arrange the prompt transfer to long-stay annexes of all irremediable patients. (7) To assess, and periodically to review, the suitability of all patients recommended for long-stay annexes so as to ensure that no patient shall be regarded as irremediable while still capable of further improvement. (8) To assist generally in the co-ordination of medical and medico-social work for the elderly sick. (9) To provide, on request, for general practitioners under the domiciliary health services special advice about their elderly patients at home or in consultative clinics. (10) To afford facilities for expert advice on the medical aspects of welfare or housing schemes for the aged. (11) In selected departments to provide teaching in the geriatric aspects of medicine, nursing, and physiotherapy. (12) To encourage research in geriatrics and gerontology.

35. *Long-stay Annexes.*—As long-stay annexes provide the outlet for the "20% residuum" of irremediable patients from the geriatric department, they are possibly the most important component of the whole co-ordinated service; for without adequate provision of such annexes the whole scheme is bound to fail. Their functions are: (1) To receive patients for nursing care who are no longer likely to benefit from treatment in the geriatric department. (2) To refer patients back to the geriatric department if a change in their clinical condition warrants readmission for treatment. (3) To maintain continuity of medical supervision by the geriatric and other departments of the hospital. (4) To provide a more homely atmosphere for the chronic geriatric patient under suitable medical and nursing conditions.

36. As stated, these annexes exist for the reception of the "20% residuum" of patients needing transfer from the geriatric department. To ensure that no remediable cases are admitted without prior investigation they should receive patients from no other source. With suitable classification the irremediable patients admitted to these annexes come under two main headings: (1) those who require to be segregated either in groups or singly, whether for the sake of other patients or because they themselves need privacy; and (2) those who on medical grounds require no special allocation. Grouped segregation is advised for cases of permanent incontinence and for patients with senile dementia, many of whom are best nursed in cot beds. Individual segregation in single wards will be needed for those in great pain, for patients whose condition would be distressing or offensive to others, and for the dying. For the remainder, who require no special allocation on medical grounds, the grouping will be purely social, its basis being that of temperament or mutual interest. Most of these patients will be kept permanently bedridden by their disability, but some, too frail for a residential home, will often be able to get up for part of the day. They should lead as normal a life as their infirmity allows, and they need diversional therapy and suitable recreation.

37. A long-stay annexe should be a unit of not more than thirty beds, subdivided into four-bedded sections and with ample single-bedded accommodation. Ideally it should be single-storied and have access to sheltered verandahs and a garden. A day-room suitable for religious services, concerts, and film shows is almost essential. Until the building situation improves, such plans will not often be practicable, but in selecting the best accommodation available in each locality these points should be borne in mind.

38. Large independent hospitals or institutions for the chronic sick are to be deplored. As those that already exist may have to be used for some years, it is suggested that they could accommodate long-stay geriatric patients. Provided that these patients were suitably classified and were grouped on the lines that have been suggested, an imaginative use of one such building, geographically suitable for patients' visitors, could make it serve the purposes of several long-stay annexes. While the geriatric department of the general hospital may in some cases need to be at a distance from the centres of population which it serves, a long-stay annexe should *always* be situated near to the relatives and friends of the patients occupying it, inasmuch as it constitutes their home for the remainder of their lives. But it should be remembered that, wherever situated, the long-stay annexe must remain directly under the medical administration of the geriatric department.

39. *Chronic* geriatric patients, who call for very high nursing skill, make exacting demands upon the endurance and patience of those who nurse them. Such nursing may perhaps more easily be sustained by part-time staff who can look forward to returning to their own home surroundings after a relatively short spell of duty. As long-stay annexes will usually be in more populous areas, the transport of non-resident staff should present no insuperable difficulties. Therefore it is suggested that the staffing of these annexes would very suitably lend itself to a part-time nursing scheme, such as that operating in Gloucestershire. Working with this part-time staff, there should be a number of well-chosen assistant nurses, under the over-all supervision of a trained nursing sister. Assistant nurses, who have in the past proved their value and often their special aptitude in caring for chronic elderly sick, would find scope and experience in long-stay annexes which might later fit them for promotion to posts of administrative responsibility in residential homes.

40. *Residential Homes.*—To complete the scheme, accommodation in residential homes must be provided for homeless patients whose treatment has been completed and who are fit to be discharged. Unlike the long-stay annexes, these homes will not be under the administration of the regional hospital boards, but it is of the first importance that they should maintain close consultation with the hospital geriatric departments. It is idle to speculate on the exact number of additional residential homes which will be needed in any locality. This will depend upon the number of old people in the district, the proportion of these old people suitably accommodated with their families or friends, the existing provision of private dwellings for the elderly in local housing schemes, the number of residential homes for relatively able-bodied old people already provided by the local authority, the number of such homes conducted locally by voluntary organizations, and the number of private hotels and boarding-houses. In short, as local conditions alone will decide the number of new residential homes required, the needs of any area can be ascertained only by a social survey of the neighbourhood. A warning must, however, be given that unless sufficient vacancies occur in these homes for old people who need them the whole system will break down, as the beds in the geriatric department will inevitably become blocked.

41. As has been observed above, in future the provision of residential accommodation for the able-bodied elderly and the provision of accommodation for the elderly sick will be the responsibilities of two separate administrative authorities, while a third authority will administer the personal medical services rendered by the general medical practitioner. The dangers entailed by this division of administrative function cannot be over-emphasized. For with advancing years the margin between sickness and health narrows, and therefore the problem of the aged cannot be divorced from that of the aged sick. Hence it becomes all the more important that there should be a co-ordinated medical supervision of *all* institutionalized aged persons (best effected by a close liaison between the different authorities) and that admission to statutory residential homes should be permitted only after assessment as to suitability by a member of the geriatric medical staff.

42. Home-residents who are taken seriously ill should in general be transferred to hospital for treatment *via* the geriatric department, and it is important that sick-bays requiring a full twenty-four-hour nursing service should not be established in residential homes. For their inclusion must be wasteful of nurses and equipment and will gradually alter the character of any home, as elderly sick will accumulate there to the eventual exclusion of the able-bodied. It is to be hoped also that in homes or hostels organized by voluntary bodies the provision of sick-bays will in general be avoided. It may be of advantage,

however, to provide a sick-room for residents temporarily confined to bed with minor ailments or stricken by serious illness likely to prove immediately fatal. It is fully realized that shortage of hospital beds may make it impracticable for the present to exclude irremediable patients, but it must be stressed that ultimately only minor maladies should be treated in residential homes. With such provisions it should not be necessary to employ fully trained nursing staff in these homes. Indeed, the warden in charge might well be appointed from well-chosen assistant nurses who have had the right previous experience in a geriatric department and long-stay annexes. In addition to making for an economy of trained nursing personnel, such an arrangement would provide scope for promotion for the really capable assistant nurse.

V. CONCLUSION

43. The Committee has decided to present this report without first examining minutely all aspects of the subject, because it hopes that prompt publication of its proposals for a geriatric service may be of assistance to the newly established regional hospital boards in planning the hospital services of the future. Owing to the present restrictions on building construction and the shortages of trained staff, progress in achieving an improved medical service for the elderly will inevitably be slow. Many years must pass before any scheme such as is advocated here can be brought fully into operation throughout the country, though the most energetic measures possible should be adopted to improve existing conditions with a minimum of delay. But, to quote a member of the Committee again, "what is needed more than anything material is an awakening of the whole community to the existence in their midst of a state of affairs often tragic in its melancholy and suffering. What was true for Piers Plowman is still true to-day. 'The neediest are our neighbours if we give heed to them.'"

SUB-APPENDIX I

Bodies which supplied information to the Committee

Ministry of Health
Assistance Board
Corporation of Glasgow
City of Salford, Civic Welfare Department
British Red Cross Society
Church of Scotland
National Society for Cancer Relief
Salvation Army

SUB-APPENDIX II

Publications Consulted

(A comprehensive bibliography is contained in *Old People's Welfare*)

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National Council for Social Service (1946). *Old People's Welfare: a Guide to Practical Work for the Welfare of Old People.* Published for the National Old People's Welfare Committee.

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APPENDIX II

THE SCOPE AND USE OF THE FILM IN MEDICAL EDUCATION

PRELIMINARY

1. The Committee was appointed by the Council on April 3, 1946, to inquire into the scope and use of films in postgraduate and undergraduate medical education. The Science Committee, which recommended its appointment, considered that a factual survey of the situation was necessary if the fullest use is to be made in medical education of this valuable visual aid. It was not generally known what films were required and what facilities were available or needed in medical schools and postgraduate meetings.

2. The membership of the Committee is as follows:

Sir Lionel Whitby, C.V.O., *M.C.*, M.A., M.D., F.R.C.P., Cambridge (Chairman).
A. Dickson Wright, M.S., F.R.C.S., London (Deputy Chairman).
Lord Amulree, M.A., M.D., F.R.C.P., London.
A. E. Barclay, O.B.E., M.D., F.R.C.P., Oxford.
V. Zachary Cope, M.A., M.S., F.R.C.S., London.
J. A. L. Vaughan Jones, M.B., Ch.B., Leeds.
R. P. St.L. Liston, M.B., Ch.B., Tunbridge Wells.
*B. G. Maegraith, M.A., M.B., B.S., Liverpool.
R. C. MacKeith, M.A., D.M., M.R.C.P., London.
*G. P. Meredith, M.Sc., M.Ed., Exeter.
R. L. Newell, M.D., F.R.C.S., Cheadle.
H. Reid, M.D., F.R.C.S., Liverpool.
C. M. Seward, M.D., F.R.C.P., Exeter.
*J. C. Spence, *M.C.*, M.D., F.R.C.P., Newcastle-upon-Tyne.
S. A. Biggart and M. Brown, nominated by the British Medical Students' Association.

3. The Committee held six meetings, has witnessed practical demonstrations on film techniques in teaching, has severally and individually sought the advice and opinions of those qualified to express views on the subject as well as calling for written reports from named teachers. The Committee appointed two subcommittees to explore and report on the various aspects of undergraduate and postgraduate medical application.

I. INTRODUCTION

4. There is no short cut to learning. Skill in teaching and the use of various aids and devices to convey information and ideas to pupils facilitate the acquisition of knowledge but cannot replace the necessity for hard work.

5. There is also no substitute for personal ability in teaching. A poor teacher will not be transformed into a good teacher by any artificial aid, however excellent that aid may be, though doubtless he will be greatly helped. A good teacher finds that he can make use of a variety of teaching aids which will convey to his pupils the knowledge and ideas he wishes to transmit in such a form that they will be readily understood and thus more easily learned.

6. Films will certainly take an increasing part in medical education, but it must not be forgotten that the film is only one of a number of visual aids and that it supplements the other various well-known methods and techniques adopted in teaching. The blackboard, the model, the specimen, the actual subject, remain standard in medical instruction. The film is a further aid to teaching. It may take the place of a lecture or demonstration or it may be an adjunct to a lecture, a permanent and standard pattern that can be employed to illustrate a subject or to explain a difficulty. The value of being able to show a perfect example by the use of a film when the teacher may only have an atypical specimen available for demonstration cannot be overestimated. In a film time and space can be overcome and events, sequences, and illustrations from different parts of the world can be collected together and demonstrated

*These members were unable to attend meetings of the Committee.

within a few moments. This is an enormous convenience both for teacher and for student. The addition of colour and sound may also, if used rightly, be of considerable value. There is danger here that the reverse may result, for though they are intended to be assets they may prove to be liabilities if wrongly presented.

7. It is essential to use the film regularly in teaching if its fullest value is to be obtained. The darkening of the room, all the paraphernalia of shutters, the squeaking of the roller screen, the focusing of the picture, all tend to distract. If necessary adjustments are perfectly executed, and if the student is accustomed to the lowering of light and the operation of the projector no distraction will occur to interfere with his following the train of instruction. He should be quite unconscious of anything but the subject. Similarly, perfect technique in presentation is essential. The lesson of the film must be free from any distraction in the way in which it is presented. Poor cinematograph technique—e.g., unsuitable movement of the camera, the hands of the demonstrator, unnatural colour, or irrelevant detail, etc.—may in themselves attract attention and take the student's mind from the subject. In silent films the noise of the projector itself is often irritating and hinders a satisfactory spoken commentary. *Perfect films and perfect projection are essential or much of the value of this method of teaching is lost.*

8. There are many different types of films which may be adapted to the various circumstances of teaching. The length of a film is important and should be appropriate for particular purposes. It is well described in the following way—viz., sentence, paragraph, chapter, and essay films. The sentence film illustrates one particular item which the teacher desires to explain or demonstrate—e.g., a movement, a reflex, or a manipulation. It might run for only half a minute and the lecturer will use it as a lantern slide to show the detail of his particular point. A paragraph film would be slightly longer and might show an incident and modifications, with shots taken from one or another angle or in slow motion. The chapter film deals with that portion of a subject which is circumscribed and can be presented as a whole. An essay film deals with a whole subject and is complete in itself.

9. The longer type of film which might run for 20 to 40 minutes would be complete with commentary and captions and would be more suitable for meetings of practitioners rather than routine teaching. A series of short films is more effective for students than one long film. The spoken commentary in the film has the advantage of being concentrated and authoritative and closely related to the pictures. It has the disadvantage that the subject matter is expressed in words other than those the teacher himself would choose, and may in the opinion of the teacher either under- or over-emphasize various points.

10. A special section of this report is devoted to the film strip (see Section III), which can be an extremely valuable aid for teaching and which has special scope and application and presents its own peculiar problems.

II. PRINCIPLES AND TECHNIQUES EMPLOYED IN TEACHING WITH FILMS

General

11. In considering the scope of films in medical education the broad aims of medical teaching should be borne in mind. These are to furnish the requisite knowledge, develop judgment and skill, cultivate the right attitude towards patients and give opportunities for experience, and to encourage students to think for themselves.

12. Only knowledge and understanding can be imparted by means of the film in education. To a lesser degree the student's attitude to medicine and its various branches can be moulded by the film, but his experience, skill, and judgment cannot be materially influenced by means of the motion picture. For this reason the teacher must beware lest, by the use of this aid in teaching, he falls into the error of thinking that more than actual illustration and exposition has been accomplished when films have been used. There is no substitute for the actual carrying out by the student of processes and techniques in which he must become proficient.

13. In approaching any subject of the curriculum or any part of a subject the student can more readily understand if it is summarized for him. The film performs this function with great facility. He can thus be given a general view of the ground he is to traverse and so avoid the usual confusion which results from the initial study of the detail of any section of the subject. There is a great need for films of this nature; they would also be of value for revision purposes.

Technique

14. Every opportunity must be given for the student to assimilate and learn the lesson. The avoidance of eye strain by optimum illumination is important. Observations have been carried out in Australia and America on the relative value of black-and-white and colour photographs: the results are as yet inconclusive.* Too strong or too weak illumination proves to be a great disadvantage. Opportunity for note-making should be given. This may follow the film, and the film can be shown again to give an opportunity for the student to pick out points he may have missed or wishes to reobserve.

Limitation

15. Teaching by means of films is limited by the films available. These in turn are limited by lack of organization and money. Production should be in accordance with accepted needs and for specific purposes. At present teaching is adapted to the film rather than the film being prepared for the needs of teaching.

Production

16. Scientific films cannot be economically produced, but their value should be measured in the saving of time and improved methods of teaching, and not in terms of expenditure.

17. Since films are expensive to make it is unlikely that the advantages of this method of teaching can be fully obtained until money is available for the production of the type of film that is needed. It is hoped that in the future charitable donors will be encouraged to support this method of teaching.

18. The presentation of movement as a teaching aid is of unique advantage and is only obtainable by means of the film. Physiological processes such as the movement of joints or of the alimentary tract in cineradiography, abnormal movements, incoordination, gaits, nystagmus can only be portrayed by the medium of the film.

19. The use of instruments or apparatus, operative techniques, manipulation, the handling of the unconscious patient, and techniques of plaster-of-Paris work are well illustrated by film. To appreciate the technique of particular surgical operations prior to the actual witnessing of operations would be advantageous.†

20. The student is at a disadvantage if he cannot see what the operator is doing and describing, consequently a cinematograph record of work performed by a surgeon, as for example through a bronchoscope, laryngoscope, or cystoscope, would be of great value.

The cinematograph has been used both for research and teaching to demonstrate subjects viewed by the microscope. The behaviour and movement of parasites, the microscopic processes of inflammation and cell division, are examples of its use. By different methods of lighting it is possible to illustrate different types of work. Reflected and transmitted light and dark-ground illumination are of special value in demonstrating various microscopic movements. The alterations of speed of movement in the slowed motion or in speeded motion are of particular note. The deft movements of the hand in some difficult techniques can be slowed up to show the exact process. The life cycle of a parasite can be condensed into a few moments, enabling it to be easily understood.

21. The film is of value for case records—a typical or an unusual case can be recorded permanently to be shown as desired.

**Films: Their Use and Misuse* (Part I), by H. N. Rosenthal (Melbourne).

†In connexion with the teaching of operative surgery the possibility of the use of television is to be envisaged. By means of the television camera students could obtain in another room a close-up view of the field of operation.

22. Another use is the assembling of apparatus for, say, a blood transfusion, lumbar puncture, operation, etc. The placing of separate pieces of apparatus in turn upon the screen familiarizes their appearance and rivets their necessity.

23. The use of the diagram built up by animation and superimposed upon the actual subject might be of great advantage in the teaching of anatomy, physiology, and pathology. Inflammation, the effects of emboli, and lymphatic drainage can be clearly portrayed. In embryology, fertilization, mitosis, the formation of ectoderm and endoderm and the formation of the placenta are examples which readily come to mind.

24. Films should be related to other educational material. Textbooks, handbooks, and broadsheets may, if necessary, be specially produced to accompany certain films, enabling the student to study and learn the subject in his own time. The showing of the films will help him to understand a process easily, but unless he takes pains to learn it is doubtful whether he could remember and apply what has been illustrated.

25. Each teaching hospital and medical school should be equipped with projectors for film and film strip. There should also be available standard films of the sentence, paragraph, chapter, and essay type available for use at the hospital or school when required.

III. THE FILM STRIP

What is the Film Strip?

26. A series of pictures or diagrams on a length of film with or without amplifying caption, or a caption or title by itself, all in a logically designed sentence. In other words a very much improved type of "magic lantern."

How is it Used?

27. The film strip is used with a still projector which is characterized by its extreme portability. The apparatus is simple and cheap to produce. It can be used in a semi-darkened room. It is most useful for small groups of students in tutorial classes. It is used simply in the course of a lecture or demonstration as lantern slides are now employed, or the whole lecture or demonstration may consist in showing a very large number of "frames." The "quarry" type of film strip contains a large number of illustrations. The lecturer can pick out the ones he needs to illustrate his points. A "library" of illustrations can be built up of, say, skin conditions in colour, pathological specimens, and so on.

Why is it Used?

28. It enables the instructor who employs it properly as a visual aid to teaching to implant knowledge more deeply by using the sense of sight as well as that of hearing. This makes a more lasting impression on the mind, and interest in the subject is increased.

What can it Do?

29. Used correctly the film strip can, among other things, (*a*) enable the instructor to take the class logically over the lesson, step by step, at any desired rate; (*b*) provide natural opportunities for questions and answers and for discussion on any important points; (*c*) reduce to a minimum the need for unwieldy wall diagrams and tedious blackboard drawings; (*d*) provide good instructional material anywhere, however inconvenient; (*e*) associate ideas with pictures and diagrams which will live in the memory.

30. In all the above points except the last the film strip is better than the film, and in the last it is as good.

31. Films and film strips are probably the most closely related visual aids. The publication of associated notes in each case is of value.

How is it Prepared?

32. Photographs are taken of pictures, diagrams, apparatus, captions printed on cards, etc. These are assembled in their correct sequence and are photographed on to a length of film.

33. A film strip may thus be prepared for a specific lecture, or standard strips may be prepared and duplicated.

IV. FILMS AND MEDICAL CURRICULUM

Undergraduate Training

34. The giving of an occasional film display for medical students is generally productive of great interest and increased attendance. Frequently it is not of very great value from an education ("examination passing") point of view because the film which covers a subject from beginning to end is not as a rule made. The films in existence are very often made to illustrate some special technique of anaesthesia, surgery, or obstetrics. Purely medical films are scarce and often illustrate some rare disease. They make a lasting impression on the mind of the student. The showing of these types of films is generally the result of the enthusiasm of some member of the teaching staff who has a special interest in films and has made a few films of his own. Insufficient understanding of the best method of use has prejudiced many experienced and even progressive teachers against the film.

35. Quite on a different plane would be the gradual incorporation of short films into a lecture series as organized by a teaching unit. Here it is the custom for each lecture to have its appropriate lantern slides and epidiascope, diagrams, and pictures, all kept systematically in a file.* It would not be difficult to introduce into these files appropriate films which would add greatly to the cogency of the lectures. These lectures would be built up gradually and improved upon in the course of the years. Furthermore, the director of such a unit might become inspired with a desire to make films for the distinct purpose of teaching, and copies of these might find their way to other teaching units. At present it is hard to think of any other source of the real teaching film. Others in the profession make films to illustrate their own theory or technique and do not wish to introduce expensive material of an introductory or explanatory nature. The animated diagram would of course be of the greatest value in teaching many things in medicine, but who will have the time and money for making such films, and what would be the financial return on them? Possibly grants could be made from certain funds for this purpose. Embryology is undoubtedly a subject which is hard to teach by word of mouth and two-dimension drawings; films on this subject would be of the greatest interest and value. A limited number of films of operations are valuable, although for instruction actual attendance at the theatre whilst the operation is in progress is preferred. It is of value, however, to condense a forty-minutes operation to ten minutes by means of a film. Waste of time by students watching operations can thus be overcome. The student needs to be shown surgical technique but does not need to watch a large number of operations in the theatre, as is the present custom.

36. There will always be the need to guard against the overuse of films. For a teacher, it may be a lazy way of lecturing, and in general a film cannot impress in the same way that a good teacher can by word of mouth. The film is still a novelty to people, and its limitations must be learned by experience. Moreover, the temptation to show a film instead of a suitable patient must be avoided. *Teaching films must be kept in their proper place in the curriculum if the best results are to be obtained.*

37. To be of utmost value as a teaching instrument films should be used regularly. They should never be used as a substitute for normal teaching but only as an adjunct. The novelty of showing a film may detract from its value unless it is a usual event during the course of lectures. The use of motion, sound, and colour should rest in the discretion of the teacher. In other words, the teacher would himself decide what type of film he wanted and whether it was to his advantage to use such films as were available.

38. The film has probably two main roles: (*a*) The longer—i.e., "chapter" or "essay" film—tells its own story on a particular subject; that is, it acts as a visiting lecturer in the sense that it may put a slightly different point of view from that held by the usual teacher. Such films will be as long as is required for the description they are giving or the argument that they are developing. They might run for 15 to 40 minutes.

*The film strip is rapidly taking the place of these more cumbersome aids.

In films of this type the peculiar advantages of the cinema would be gained—that is, in presenting material for the purpose of comparison or contrast—although the shots from which the films have been made were not necessarily related as they were being taken. The cinema offers this opportunity for a synthesis of events which were actually separate in time and space. (*b*) The shorter, or " sentence " and " paragraph " films, which tend to demonstrate one particular point rather than cover a complete subject, are better suited for the purpose of undergraduate medical education. They serve to illustrate the teacher's own development of his subject. Used in this way the film may be an " animated lantern slide." Animated diagrams may be employed for the presentation of complicated ideas.

39. The film offers special scope for teaching. The animated diagram, the cartoon film, normal photography, or a combination of these types might be specially applied to different subjects. When appearance is important in the topic actual photographic shots are essential. When structure, relations, and processes, the course of impulses or the combination of movements, etc., are to be illustrated, diagrams, both stationary and animated, are appropriate.

40. The making of films depends largely on the initiative and need of teachers in the medical schools, and this emphasizes the need for the establishment in all teaching hospitals of photographic departments, in which their own simpler films and film strips can be produced. Information has been obtained as to the extent films are being used for teaching purposes in the medical schools, and this will be found in Sub-appendix D.

41. The Committee has surveyed the types of film which could with advantage be utilized as aids to teaching the various sections of the medical curriculum and submits the following examples:

Anatomy

The following types of cinematographic aids to visual appreciation would be of value:

1. Silent captioned films (generally black-and-white, but in colour where of special value) of the living subject for showing: Actions of muscles in the normal living subjects. Variations of stance, posture, bodily habitus. Pareses and paralysis of muscles (from clinical material). Distribution of nerves (as exemplified by disabilities following injury or disease). Endoscopic appearances of body cavities, etc. Early development of (living) cells and tissues. Patterns of behaviour in experimental animals.

2. Short silent films (like 1, above) of the cadaver for demonstrating: Special regions, dissections, preparations, etc., to a large class. The technique of dissecting. The relations of body-planes and layers.

3. Cineradiographic films for showing: Movements of joints. Movements of parts of the alimentary canal. Movement of thoracic viscera.

4. Animated cartoons (non-coloured or coloured): In embryology, for showing successive phases of tissue-, organ- , or region-development. In neurology, for representing the course of impulses along nerves and fibre-tracts. In arthrology, for illustrating muscle and joint actions.

Physiology

Long films dealing with a whole subject. Examples of these are:

Methods of measuring cardiac output in man. Movements of the alimentary tract (cineradiography). Mechanisms of respiratory movements (straight cineradiography, cartoons, *x*-ray cinematography). Conditioned reflexes. Methods of making dietetic surveys. Cellular anatomy and physiology, live tissues, and tissue culture. Capillary circulation. Circulation of the blood. Arteriovenous anastomosis. Lymphatic system.

Short films dealing with particular topics: Many classical demonstrations in experimental physiology could be shown with advantage in the course of lectures, but should not be used to supplant actual demonstrations, which might, however, be reduced in number. Such demonstrations might be:

Measurement of arterial blood pressure. Observation of the exposed heart. Effects of stimulating cardiac and vasomotor nerves. Effects of haemorrhage. Reflex action, stimulation of vagus, cortical localization. Biological assays.

Demonstrations of clinical cases which may not be available at the required time in a systematic course; for instance, neurological cases, showing the effects of nerve lesions, cerebellar lesions, endocrine-gland disturbances, disorders of the circulation, pulsation in vessels, venous pressures, oedema, dyspnoea.

Medicine

The following types of silent captioned films would be of value:

Actions and reactions of drugs on human and animal subjects. The aetiology and clinical manifestations of certain specific infections, smallpox, anthrax, etc. Diagnostic techniques—e.g., lumbar puncture, marrow puncture. Clinical techniques, aspirations, blood transfusions, artificial pneumothorax, the use of apparatus—e.g., ophthalmoscope, auriscope, laryngoscope. Diseases of the chest or other system. Neurological subjects, etc., when suitable; typical gaits. Syphilis. Parasites (e.g., tapeworm: life history, diagnosis, and treatment).

In the following, *sound* could be incorporated with advantage:

Demonstration of routine clinical examination, including simple manœuvres. Clinical case histories, typical cases—e.g., aphasias or rare conditions. A film of an electrocardiogram with accompanying heart sounds would be of special value. Cardiac and respiratory sounds, both normal and abnormal, could be demonstrated by means of sound-films. The teacher can thus be certain that his class knew exactly what he was demonstrating. Often the student may listen in the wrong place or apply the stethoscope badly or miss altogether the point being demonstrated. This could well be achieved with the cartoon type of films.

Paediatrics

Typical and atypical cases; special techniques. Most of clinical paediatrics consists of dramatic short illnesses with rapidly changing signs and symptoms, and under present conditions a very small proportion only of students and doctors can get practical experience in this field of medicine. This is therefore a field which lends itself particularly well to illustration by films.

Surgery

Generally, films of major operative surgery should not be made for undergraduate use, but the following types of film are considered to be of value for teaching purposes:

Examination of a patient with certain surgical conditions—e.g., acute abdominal diseases, method of examination in cases of joint injury or disease. Orthopaedic subjects. Examination of injured persons. Minor operative procedure. Plaster-of-Paris techniques. Reduction and fixation of fractures. Anatomical abnormalities.

Midwifery

Apart from films on general medical and surgical subjects which have a bearing on pregnancy, silent captioned films showing:

Abnormal presentations. Mechanisms and techniques in delivery, diagrams or films of model pelvis and doll. The various stages of prenatal development.

Pathology

Post-mortem examinations and microscopical study of tissue must always form the basis for teaching this subject, but the film has an obvious place for giving a general survey of the subject and, secondly, for linking pathology with clinical medicine. Composite films showing the clinical manifestations of a pathological process from the earliest detectable point to the termination, associated with the pathological changes at each phase, are invaluable for making the subject of pathology the fundamental basis for good practical medicine. The lantern slide and the film strip are most efficient instruments for teaching routine pathology—e.g., histological detail when the projected image is all-important. Such methods are seen at their best as a class demonstration preceding individual study of material with the microscope. The film itself has a great value in bringing to life and teaching such matters as:

The development of blood cells in health and disease. Tissue culture. The stages of inflammation. Thrombosis and its complications. The life history of malarial and other parasites. Tropical diseases. The examination of stools. (Colour films are particularly impressive.)

Industrial Hygiene and Disease

The following types of sound films would be of value:

General survey of industrial diseases. Incidence and prevention of occupational disease. Dangerous trades. Aspects of ventilation, heating, illumination, noise, and vibration. Accident prevention. Industrial processes. Motion study. Industrial resettlement.

Hygiene and Public Health

The following types of sound and silent captioned films would be of interest:

Social medicine, including population analyses. Sewage and water supplies; pest control; ventilation. Smoke abatement. Housing, slums, etc.

Forensic Medicine

The following are types of films that would be of value: Poisons—diagnosis and treatment (e.g., arsenical poisons); and post-mortem changes.

Note: The replies of the deans of medical schools and various learned societies to a questionary circulated in 1945 by the Medical Committee of the Scientific Film Association have been collated and published as a *List of Subjects on which Films are desired in Medicine*, by the Scientific Film Association.

42. *Propaganda.*—There is a place for propaganda films for students and nurses. Suitable subjects might be: (1) the need for early diagnosis of cancer and how it can be achieved. (2) The importance of asepsis and the methods of achieving it. (3) Antenatal and post-natal services—rehabilitation, etc. (4) The dangers of infection in nurseries and measures to control it, etc.

V. POSTGRADUATE APPLICATION

43. In this section the Committee has confined itself to the needs of the general practitioner. Undoubtedly films for specialist study would be of value and might be produced and used in the same way as those recommended in the undergraduate section.

44. Essay and documentary films are needed for the general practitioner, who has all too little time to keep abreast with recent advances in medicine. They may give him general information upon specialized subjects or detailed instructions in his own sphere. If there were regular productions of such films to ensure plentiful supply there is no doubt that they would be extremely popular with doctors throughout the country and would help to raise and maintain the general standard of medical treatment in practice.

45. The Council of the Association has expressed the opinion that the monthly (or, better still, weekly) meeting of the profession at the local hospital is one of the most valuable methods of promoting postgraduate education, and should be adopted in every area where there is a hospital with upwards of 200 beds. It has also suggested that in the areas furthest removed from teaching centres, where facilities are most urgently needed, the instruction should be in the hands of the local consulting staff of the hospital, with the aid of visiting teachers. Thus the local 200-bed hospital would become the centre of clinical instruction; and this arrangement would relieve to some extent the pressure now being put on the teaching staffs of University centres and overcome the difficulty of combining postgraduate with undergraduate education. The opportunities for use of the film for postgraduate education thus become apparent, and would be possible if more projectors were available.

46. The general practitioner appreciates the type of film which is complete in itself and surveys a subject. There is a considerable demand for this type of film to be shown at local B.M.A. Division meetings. These film shows are popular but extremely difficult to arrange. There is no one single and comprehensive catalogue with assessments of films. The organizer of such a film show is faced with the problem of not knowing which films to choose and whether the films chosen will prove attractive and instructive. He has also difficulty in obtaining an operator and projector, and he may have to borrow films from a number of different bodies or private sources. These obstacles are sufficient to prevent the frequent use of this valuable means of postgraduate instruction.

47. The Central Office of Information has a limited number of films (see Appendix B) and is prepared to provide both an operator and a projector if sufficient notice is given.

48. There is no central B.M.A. bureau where information upon all medical films is obtainable and which can arrange for film shows in a Division as required. A choice of several balanced programmes should be available, or Division secretaries could make up their own programmes from the information provided in a catalogue.

49. There is no adequate Medical Film Library. The Central Film Library* has only a small medical section; the Kodak medical film library, now in process of being transferred to the Central Film Library, is incomplete and does not contain the more up-to-date films. Commercial firms and private sources offer only a limited variety of films. Copies of all suitable films need collecting into one library which would then serve the profession as a whole.

50. The Scientific Film Association maintains a master catalogue of medical films. It provides information, including suggestions as to programmes for medical groups, books, films for B.M.A. and other meetings, and also holds for use of its members a number of films presented to it chiefly from overseas.

VI. PROBLEMS OF PRODUCTION

51. Production of medical films is, on the whole, dependent upon the interest and enthusiasm of amateurs and those who have wished to document a factual record of certain work done. There is no central organization for the production of medical films. Because of this production and planning has been haphazard and uncoordinated, with a tendency to overlapping.

52. The Ministry of Health has prepared a few films such as those on scabies and penicillin. A few films have been made in the course of research work, Canti's film on tissue growth being a good example.

53. The production of simple films could well be carried out in the photographic departments of the larger hospitals, which might possibly obtain the backing of the University Grants Committee. Alternatively, if funds were available, an Institute of Medical Cinematography might be established, with the co-operation of a number of hospitals to maintain contact with the various medical schools and small production units. It could, in addition to acting in an advisory capacity, produce standard films on important subjects and also be available for the production of documentary films for historical purposes. It is realized, however, that this suggestion might not be practicable at the present time and therefore some central body would be necessary to act as a clearing house and to keep in constant touch with hospitals and medical schools. A scheme for full co-ordination in the production of medical films is already in operation by the Scientific Film Association. The Committee is of opinion that this could well be undertaken by a standing committee of the Association set up to deal generally with matters concerning medical films.

54. The problem of production is fundamentally an economic one. The type of film that will be of most value to medical audiences must be produced under the direction of medical experts. In the past professional photographers have been more accustomed to the production of documentary films than those used for teaching; they are inclined to consider the artistic effect rather than the teaching value, and they have failed to recognize the importance of the method of presentation of subjects for medical teaching. These problems should not be difficult to surmount. The importance of the presentation of the subject from the teaching point of view is now recognized, and there is scope for development.

55. The Committee acknowledges the value of the many excellent medical films which have been produced by commercial undertakings and it would not discourage this method of production provided objectionable advertising material is not included.

*The film library of the Central Office of Information.

VII. CONTENT, APPRAISAL, AND GRADING OF FILMS

56. By the expression "the content of a film" is meant a factual statement of the matter dealt with in the film. An "appraisal" is a critical judgment of the quality of the film for the purpose for which it is used. To be authoritative appraisals should be the joint work of an expert group. "Grading" is intended to give some idea of the value and nature of the film, its length, and its usefulness for teaching. There is a general need for intending users to be able to tell at a glance not only what is in the film but how valuable it is for whatever purposes they need it.

57. The British Film Institute, which receives financial assistance from the Government, has a medical panel, the three members of which have not met to view films for a long time. Two of them are now members of the Scientific Film Association Medical Committee which in view of its active work may take over some of the functions of the British Film Institute as regards medical films. The Scientific Film Association's Medical Committee has published studies on the problem of appraisal of medical films.

58. Some years ago the Scientific Film Association started to catalogue films, and the Royal Society of Medicine made a grant to the Scientific Film Association to pay the salary of a cataloguer, who worked at the Royal Society of Medicine, with clerical assistance provided by the Royal Society of Medicine. Titles of 1,200 films were recorded and 800 were actually noted. After two supplementary grants the Royal Society of Medicine withdrew its grant on grounds of expense, and it was therefore decided to publish the material that was ready for printing (i.e., titles of 800 films inspected, with content of 200) and to publish further content summaries at a later date. The Royal Society of Medicine decided not to include critical analysis of films, but merely simple descriptive statements. On the other hand, the Scientific Film Association felt that a catalogue with appraisals was essential, and they accordingly began to publish catalogues of this nature, with a critical catalogue of films on anaesthesia. Lack of funds has prevented the completion of this creditable effort. There is need for a central appraisal unit with regular publication of up-to-date catalogues or lists.

VIII. A MEDICAL FILM LIBRARY

59. In order to satisfy the demand for medical films and facilitate their distribution, the Committee strongly recommends the establishment of a medical film library. A number of small lending libraries is not satisfactory.

60. In 1938 the Conference of Honorary Secretaries of Divisions and Branches of the Association asked the Council to consider the advisability of establishing a film library for the use of Divisions and Branches, and the matter was referred by the Council to the Organization Committee. In its report the Committee urged the Council to take action, and the Council voted the sum of £50 for the purchase of films "during the next twelve months," but the outbreak of war prevented further action.

61. The B.M.A. should consider setting up its own film library, but there are special problems involved in its establishment which require mention.

62. The Committee has accordingly made preliminary investigations into the establishment by the Association of a medical film library and has ascertained that it would be essential to provide storage accommodation, an office, and a workshop, complete with bench and projector, winding, and repair apparatus. The necessary staff would consist of a technician and a clerk.

Storage

63. The storage of 16-mm. films presents no problem. A cool chamber with adequate shelving space is all that is required. The Garden Court Wing in B.M.A. House is expected to become available for the Association's lending and reference library and there is space in the basement which might be made available for a film library if required. In the storage of 35-mm. films special fireproof precautions are necessary, but as these films, which are inflammable, can be shown only in properly equipped theatres with a fireproof projection chamber they would not be appropriate for medical schools or occasional shows to medical audiences in various places.

Maintenance

64. The technician, in addition to being responsible for the storage, would examine all films before and after use and effect the necessary repairs. He would be responsible for the issue and return of films as they were required. The clerk would keep records and arrange bookings, postages, packing, etc.

Films

65. The most appropriate film for a library of this nature would be 16 mm., both silent and sound. For an effective library at least 200 films would be necessary. Copies of films could be obtained at a cost of £4 per reel (approximately 400 feet) in the case of 16-mm. sound films; the silent films are rather less—namely, £3 10s. per reel of the same length. The "life" of a film averages 5 to 50 showings, depending upon the frequency of use. The base of films tends to deteriorate after five years. The experience of two well-known commercial libraries is that, exclusive of the cost of printing, the administrative cost of showing a film is approximately £1.

66. There is a great potential historial value in documentary films, and this aspect of the suggested project would be borne in mind in connexion with such a film library.

Cost

67. The Committee estimates that the initial cost of establishing a medical film library would be in the region of £2,000, made up as follows:

Purchase of copies of films	£1,500
Purchase of projector and associated equipment (repair kit, shelving, records, etc.) ...	£500

The annual maintenance costs (excluding overheads, such as lighting, etc.) are estimated as follows:

Salary of technician and clerk	£750
Maintenance costs	£250

The Committee finds it difficult to assess the annual recurring financial liability once the library has been established, but the experience of the Royal Society of Medicine, the Scientific Film Association, and the Central Film Library lends support to the belief that this could be very considerable. The extent to which the library should be used, whether films should be loaned to medical schools as well as to Divisions and Branches, and if so whether a charge should be made for the loan, the replacing of worn-out films, whether other than purely medical audiences (e.g., nurses, health visitors) should be allowed to borrow the films, are important considerations in assessing the financial details of such a library. The experience of the American Medical Association in maintaining its medical film library (see paras. 69 and 70) is, however, a useful pointer to the probable financial outlay. If the principle of the establishment of a library is conceded by the Council, the Committee could make full investigation into these questions and prepare a detailed statement.

68. To enable members and Division Secretaries to obtain the relative information about films the Committee is of the opinion that a bureau of inquiry organized by the Association is highly necessary. Clearly it would be some years before a library would come into full functioning capacity, but such a bureau should at once give information to inquirers, and later would be the administrative machinery of the film library. The Committee therefore suggests that the Association should set up under the control of a standing committee a central bureau of information on all matters appertaining to medical films for the use of Divisions and Branches, to issue recommendations, leaflets, short accounts of films, etc., and to help in every way to assist the running of film shows. It would be necessary for the bureau to be fully established before it could be publicized.

The Position in America

69. Inquiry has been made of the American Medical Association as to the cost of setting up and maintaining its medical film library and the following information has been obtained:

"In 1928 and again in 1930 the House of Delegates appointed committees to study the problem. The Bureau of Exhibits has developed a source file of motion pictures and has maintained a small film library for the past fifteen years. In 1945 the Board of Trustees, at the instigation of the Committee on Scientific Exhibits, appointed a Committee on Medical Motion Pictures to make suggestions and report back to the Board. At the San Francisco session the Trustees accepted the recommendations and appointed a committee with the following objects: (1) To promote a more widespread and effective utilization of medical motion pictures and to stimulate research in this field. (2) To expand the present library of medical and public health films now available on a loan basis through the American Medical Association. Motion pictures dealing with basic subjects that are not available through other sources will be selected. Additional copies of the most popular prints in the present library will be purchased so that a wider and more rapid distribution will be possible. (3) To publish critical reviews of medical motion pictures in the *Journal of the American Medical Association* and *Hygeia* from time to time. These reviews will include a brief description of the film content, a professional and technical appraisal, a comment as to the recommended audience level, and a note regarding the availability of the films. Current news items of interest to the medical profession as well as comments on the intelligent use of motion pictures will also appear in the journal. (4) To expand the source file which has been started. Eventually this file will contain informative data on motion pictures dealing with all phases of medicine as well as health films for the public. Films not available for loan or purchase will not be listed. The purpose of this file is to provide on request authentic information relative to the types of film available to the medical profession on any given subject. The compilation and maintenance of a file of this type is a large undertaking. As far as facilities permit, it is planned to co-operate to the fullest with medical schools, State and county medical societies, Government departments, foreign countries, and other groups interested in the dissemination of knowledge and information on the subject of medical motion pictures."

70. The following further information has also been obtained:

"We now have a total of 153 prints and approximately 47 titles. All requests for the loan of our films are sent direct to this office. In the past these requests were forwarded to a commercial film library here in Chicago where our films were stored, shipped, and inspected. This library made a charge of 50 cents per reel for handling and inspecting. Inasmuch as we did not feel that our films were receiving adequate personal attention, we decided to hire a film technician and maintain our own library here at this headquarters. If our activities were limited we would require one typist, and one film technician who carefully inspects each film upon its return. However, we also act as a clearing house on all matters relative to medical motion pictures. This includes the maintenance of a rather complete source file. In another month or two our staff will consist of one director, one medical record film librarian, one secretary, one film technician, and one clerk-typist.

"The film library can be the source of many problems. For example, our films are not always returned promptly, and this of course constitutes a rearrangement of our schedule; telegrams must be sent reminding the borrower that the film is overdue and requesting information as to date of return shipment. It is also necessary to advise the next user that the film has not been returned and may not be available for their showing as scheduled.

"Our film library was started over ten years ago and additions have been made from time to time. I would say that the library now represents a total investment of approximately $15,000. This year I have asked for $10,000 in order to buy additional pictures and replace some of our films which are badly worn. Our primary concern lies with the State and county medical societies. Many hospitals and medical schools also request the loan of our pictures. However, it would be financially impossible for us to maintain a complete library which would serve adequately all of our seventy-seven medical schools."

ACKNOWLEDGMENTS

71. The Committee wishes to express its thanks to the Directors of Gaumont British Instructional, Ltd., for their courtesy in putting their private viewing theatre at its disposal, Miss Simpson (Gaumont British Instructional, Ltd.), Lieut.-Col. Salusbury, Director of Army Education, Commander Burnett, R.N., Mr. R. L. Newell, and Mr. Hugh Reid for their demonstrations; and to Prof. Jeffcoate, Mr. A. Dickson Wright, Dr. Ackroyd, Dr. Brian Stanford, as well as to the British Medical Students' Association and the Scientific Film Association. The thanks of the Committee are also due to Mr. G. P. Meredith for allowing extracts from his published observations to be used in the report, and to Prof. A. Hemingway, Prof. A. J. E. Cave, and G. P. McCullagh for their help in connexion with the work of the undergraduate section of this report.

SUB-APPENDIX A

Survey of Available Medical Films

The Committee has made a survey of medical films in this country in order to ascertain from whom and under what conditions they can be loaned for showing to medical audiences. The total number of medical films is in the region of 800 and they are held by the Central Film Library of the Central Office of Information, the Royal Society of Medicine, the Scientific Film Association, University and hospital departments, commercial firms, and private individuals. In some cases they are loaned free of charge as in the case of the Central Film Library (see below); in other cases a charge is made varying from a guinea to cost of carriage only. Up to the present no single catalogue of medical films has been published (see below). The most complete list in existence at the moment is that published in 1945 by the British Medical Students' Association. This *Guide to Documentary Films on Medical Subjects* contains the titles of some 400 films divided into two groups—namely, (1) Technical: films of use in teaching medical students. (2) General interest for societies in medical schools, etc., wishing to show films on subjects allied to medicine (e.g., sanitation, housing, food production, care of children). The guide contains information as to whether the films are silent or sound, 16 mm. or 35 mm., time taken to show, the name of the holder, and the cost (if any) of hire of the films. Its weakness lies in the fact that there are no appraisal notes. In fact the guide states: "Some of the films shown here may be valueless, others excellent."

A Catalogue

The Royal Society of Medicine in conjunction with the Scientific Film Association has prepared a catalogue giving the titles of some 800 films, including appraisal notes in respect of about 200 of them. This is expected to be available shortly after the publication of this report and will prove of the greatest value.

Borrowing

In general the position in relation to borrowing arrangements and appraisal of medical films is uncoordinated and unsatisfactory. Further reference to this point will be found in Section VII.

Information of some British bodies interested in medical films has been prepared with the assistance of the Scientific Film Association and is contained in Appendix C. It is not intended to be a complete list in that such organizations as those enumerated below are not included: (*a*) film-producing units (e.g., Gaumont British Instructional, Ltd.); (*b*) commercial bodies (e.g., British Commercial Gas Association, Shell, Imperial Chemical Industries, etc.) which sponsor medical films for prestige purposes; (*c*) medical associations (e.g., the Central Council for Health Education, British Empire Cancer Campaign, British Empire Leprosy Relief Association, Milk Marketing Board, National Ophthalmic Treatment Board); and (*d*) the various university departments which have made medical films.

A list of some recent medical films with content notes, owned by the Central Office of Information and available for loan to the medical profession through that body, is contained in Appendix B.

The Central Office of Information provides free of charge: (*a*) a mobile unit which carries films, projector, and screen; (*b*) generator units, which make their own current for halls having no electricity supply; and (*c*) a driver-operator qualified to give a complete show without technical assistance.

One of the difficulties in arranging film shows for medical audiences is the question of supply. Relatively few copies of each film exist, with the result that long notice is required in

order to book the required film, or it may be necessary to have an alternative film owing to the demand on the particular film required. In addition to the 800 films previously mentioned, there are a considerable number now out of date and of no practical value.

From the foregoing it will appear that there is a dearth of suitable teaching films and available copies, and it is also extremely difficult to obtain films when required.

SUB-APPENDIX B

Some Recent Medical Films

The following are examples of types of films with appraisal notes which are the product of the Ministry of Health and the Central Office of Information.

Blood Transfusion.—A survey of international progress in the practice of blood transfusion, including the discovery and significance of the blood groups (explained by means of diagrams), the use of citrated blood, whole blood, plasma, wet and dried serum, and experiments with cadaver blood in the U.S.S.R. The film indicates the experience gained in wars from 1914 on, and describes the operation of various blood donor services. 1942. 38 minutes.

Neuro-psychiatry.—A detailed account of the organization and methods of one of the seven hospitals established under the Emergency Medical Services for the treatment and rehabilitation of Service and civilian patients suffering from neuroses. The film shows interviews and talks between the staff and patients, individually and in groups, several examples of psychometric tests to assess intelligence, personality traits and vocational aptitude, and physical methods of treatment of special cases. Methods of occupational therapy in the hospital's workshops and gardens, the organization of air-raid precautions, games, and facilities for education and recreation, and the working of the welfare department are also shown. The film ends with talks between the director of the hospital and an Army officer and a Ministry of Labour official concerning the future of a number of patients about to leave the hospital. 1943. 68 minutes.

Scabies.—An exposition for doctors, health visitors, sanitary inspectors, nurses, and medical orderlies of the modern methods used in the diagnosis and treatment of scabies. The film shows the habits of the mite, the three main types of eruption and the areas of distribution, and the secondary infections which make diagnosis difficult. Treatment at a centre with benzyl benzoate emulsion (in preference to sulphur ointment) is shown and instructions for self-treatment are illustrated. The film deals, finally, with disinfestation of clothing and bedding and the examination of contacts. 1943. 36 minutes.

Scabies Mite.—Instructional film for specialists and students, showing in detail, by means of photomicrography and diagrams, the life-cycle of the *Sarcoptes*. 1943. 7 minutes.

Surgery in Chest Diseases.—A detailed study of a case of cancer of the left lung (a squamous-celled carcinoma) showing all stages, including diagnosis by radiography, the operation for total removal of the lung, and the rehabilitation of the patient. Brief glances at other cases help to fill out the general picture of the civilian chest surgery centre at which the film was made. 1944. 42 minutes.

Accident Service.—An examination in detail of the service provided for injured miners at a combined hospital and rehabilitation centre in the Midlands. To illustrate the work of the hospital, special attention is given to certain cases (fractured spine, fractured tibia, fracture of the shaft of femur, fracture-dislocation with damage to spinal cord), and there is a detailed record of the surgical treatment of a compound fracture of the tibia and fibula. The film stresses the need for rehabilitation of the whole man by removal of economic anxieties, by carefully contrived exercises, and by occupational and recreational therapy. 1944. 42 minutes.

The Technique of Anaesthesia.—These are close and detailed studies, suitable for anaesthetists and medical students. They may also be of interest to general practitioners: (1) Signs and Stages of Anaesthesia, 24 mins.; (2) Open Drop Ether, 30 mins.; (3) Nitrous-Oxide–Oxygen–Ether Anaesthesia, 26 mins.; (4) The Carbon Dioxide Absorption Technique, 24 mins.; (5) Endotracheal Anaesthesia, 26 mins.; (6) Intravenous Anaesthesia, Part 1, 30 mins.; (7) Intravenous Anaesthesia, Part 2, 25 mins.; (8) Spinal Anaesthesia, 34 mins.; (9) Respiratory and Cardiac Arrest, 15 mins.; (10) Operative Shock, 16 mins.; (11) Handling and Care of the Patient, 25 mins.

Penicillin in Medicine and Surgery.—This film is designed for medical audiences, especially general practitioners, to show the most effective methods of using penicillin. The film shows how acids and alkalis destroy penicillin and how this may be avoided; how penicillin should be kept in a cold place; and how certain antiseptics are dangerous if used with it. 1945. 35 minutes.

SUB-APPENDIX C

Some British Bodies Interested in Medical Films

The British Film Institute.—This institute was set up in 1933 to develop the use of the film as a means of entertainment and instruction. It is financed in part by grants from the Sunday Cinematograph Fund and in part from members' subscriptions. It receives and answers inquiries from every kind of source. It publishes *Sight and Sound* quarterly, and the *Monthly Film Bulletin* which contains independent reviews of feature and educational films. A large part of its work is in promoting the use of the film in education. It founded the National Film Library for preservation of all types of films of permanent value. The B.F.I. published a catalogue of British medical films in 1936 and a supplement in 1938 (both are now out of print).

British Medical Students' Association.—In 1944 the British Medical Students' Association produced a compendium catalogue of titles of medical films incorporating titles from the B.F.I., Kodak Medical Film Library, Central Film Library, and other sources. A revised second edition, including in all some 400 film titles, was published in February, 1945, and reprinted in May, 1945.

Central Office of Information.—The Central Office of Information is a Government Department which is responsible through its Films Division for the production of almost all Government films, except Service training films and a few civilian training films. The Crown Film Unit is administered by the Films Division, which also places many films out to contract with independent producing units. The Films Division also organizes a nation-wide service of mobile projectors and maintains the Central Film Library. The Central Film Library was formed in 1940 and incorporates the Central Office of Information Film Library and the pre-war Empire and G.P.O. Film Libraries, and the Physiological Film Library. All Central Office of Information films available for non-theatrical distribution are distributed by this library. It also distributes all films made by the Central Office of Information for other Government Departments and a large number of films acquired from other Governments and non-Government sources. Films in this library are available on free loan to approved borrowers.

Royal Society of Medicine.—In 1944 the Royal Society of Medicine considered the formation of a medical film library, and Messrs. Kodak presented their collection of medical films to form the nucleus of this library. The Royal Society of Medicine also made a grant to the Scientific Film Association for surveying all existing medical films, with a view to the preparation of a catalogue, and provided staff, office accommodation, etc., for the purpose. Owing to the expense of this project the Royal Society of Medicine reluctantly decided in 1946 that it was unable to proceed with the scheme. The Kodak Library is therefore in process of being transferred to the Central Film Library. A card-index of all medical films inspected in this cataloguing work has been deposited at the head office of the Scientific Film Association.

Scientific Film Association.—The Scientific Film Association was founded in 1943 to represent the interests of the users of scientific films. It acts as the overall integrating organism of scientific films. It advises on the production and use of films; it has published catalogues of films and a memorandum on the appraisal and engraving of scientific films. Through its International Committee, in co-operation with U.N.E.S.C.O., it promotes the international exchange of information and films. The publications of the medical committee include work on cataloguing, appraisals, the use of films in medical education, and co-ordination of production of medical films.

SUB-APPENDIX D

Medical Schools and the Use of Visual Aids in Medical Education

In October, 1946, a questionary was issued to forty medical schools and universities, and a total of thirty-three replies were received. The following is a summary of the replies:

Value of Films in Medical Teaching

All the thirty-three schools are of the opinion that a useful part is played in medical teaching by the use of films, although this is qualified by the statement that they are useful only in some cases and in limited fields, necessitating careful selection. The following schools state that they use films in the teaching of undergraduates:

Universities of Aberdeen (mainly silent), St. Andrews (silent and sound), Bristol (silent), Cambridge (silent and sound), Durham (silent), Edinburgh (silent and sound), Glasgow (silent), Leeds (mainly silent), Liverpool (mainly silent), Oxford (seldom), Sheffield (silent), Welsh National School of Medicine (silent and sound), University College, London, Faculty of Medical Sciences (silent), Trinity College, Dublin (silent),

Medical Schools: Guy's (silent), King's College (silent), King's College Hospital (silent), Middlesex (silent and sound), Royal Free for Women (sound), St. George's (silent and sound), St. Thomas's (silent and sound), University College (silent), Westminster (silent).

Apparatus Available

The following is the position in regard to film projectors at the various schools:

Guy's	16 mm. silent.
King's College	Kodak projector owned by school.
London	One (16 mm. silent) at the Medical College; and one (35 mm. silent and sound) at the hospital.
Middlesex	Intend to purchase one as soon as possible.
Royal Free	Gaumont British 16 mm. sound projector owned by school.
St. George's	Silent. C.O.I. supplies operator and apparatus for sound films.
St. Thomas's	Negotiating for projector which will be put in charge of department with trained operator.
St. Bartholomew's	Photographic department being established.
University College, Faculty of Medical Sciences	Silent projector.
University College	Kodak 16 mm. silent projector.
West London	Sound projector on order for medical school.
Westminster	Silent 16 mm. The department of medical photography possesses the necessary equipment for production and projection of 16 mm. silent film and double-frame film strip. Cine-Kodak special will be available in 1947.
Aberdeen University	Two 16-mm. projectors, one on order.
Anderson College of Medicine	Projector—not specified.
Bristol University	16-mm. projectors and cameras.
Cambridge University	Five projectors, silent and sound.
Durham University	16-mm. projector owned by anatomy department and sound projector by physics department.
Edinburgh University	Five 16-mm. projectors available.
Glasgow University	Three projectors and one cine camera.
Leeds University	16 mm. silent.
Liverpool	Two—operated by technician.
Sheffield University	Bolex projector.
University College, Cork	16 mm. sound.
Trinity College, Dublin	16-mm. Pathé projector owned by physiological department.
School of Medicine of the Royal Colleges, Edinburgh	Have no apparatus.
Charing Cross	
Oxford University	
St. Mary's	
King's College	
Belfast	
University College, Galway	
Welsh National School of Medicine.	

Where no apparatus is available it is borrowed from various sources (e.g., Central Office of Information).

There are insufficient projectors, and, as referred to in the body of the report, projection facilities for postgraduate work are very limited.

Film Strips

Only six schools, namely, St. George's, St. Thomas's, Westminster, University of Glasgow (one department), University of Leeds (one department), and University of Sheffield, state they use the film strip as an aid to teaching. In addition to the above, eleven schools consider that film strips could play a useful part in medical teaching, although in two cases the opinion was expressed that slides offered greater flexibility in presentation of material.

PROCEEDINGS OF COUNCIL

Tuesday, June 3, 1947

A meeting of the Council of the Association was held at Headquarters on Tuesday, June 3, with Dr. H. Guy Dain in the chair. The meeting was put forward by one day in view of the Chairman's journey to the United States, starting on the day following, for the centenary meeting of the American Medical Association. As soon as the Council assembled Dr. J. B. Miller, in the name of those present, conveyed to Dr. Dain and the other members of the delegation (Dr. J. A. Pridham, the Secretary, and the Editor) all good wishes on their visit. Dr. Dain said that he knew they would take with them to their American colleagues the congratulations and fraternal greetings of the Council and the Association. He called attention to the gift which it was proposed to make to the President of the American Medical Association in the shape of a gavel and block made from the wood of the mulberry tree which grew in the gardens of Tavistock House, the residence of Charles Dickens, now covered in part by the B.M.A. building.

A letter was read from the Royal College of Surgeons stating that it was expected that the new charter would be granted in the very near future, when it would be possible to co-opt members on the Council of the College, instead of merely inviting representatives to attend as in the past. Dr. Dain for the past three years had been the invited representative of general practice. Mr. H. S. Souttar proposed that Dr. Dain be nominated for co-option. He said that no one would be more acceptable to the Council of the College and no one would represent the British Medical Association more effectively. The proposal was agreed to unanimously.

Dr. J. W. Bone, the Treasurer, in presenting a statement of income and expenditure, said that the financial position of the Association remained very sound, but expenditure was rising, and while he agreed that all the increases were in the interests of the Association, he was bound to point out that a period was approaching when it would be necessary seriously to consider means of increasing the Association's income.

The Treasurer stated that a sum of just over £5,000, from the estate of the late Mr. E. R. Insole, had been invested, in accordance with a previous decision of the Council, with a view to applying the income to the annual award of a scholarship for research into the causes and cure of venereal disease.

The Doctor–Dentist Relationship

Dr. N. E. Waterfield, chairman of the Central Ethical Committee, reported that liaison had been established between his committee and the Law and Ethics Committee of the British Dental Association. The principal matter which had engaged their common interest was the formulation of a code of rules governing consultations, and these rules, which had already been approved by the British Dental Association as a guide to interprofessional relationship between doctor and dentist, were now laid before the Council. The rules were generally approved, though Dr. O. C. Carter drew attention to what he considered to be a contradiction, whereby in one rule it was stated that in the presence of a dental condition which might affect the general health of the patient or necessitate a major dental operation the dentist should consult the patient's doctor before carrying out such treatment, and in another rule that in a major operation the dentist should inform the patient's doctor of the operation proposed and invite him to be present if the patient

so desired. It was agreed that an endeavour should be made to clear up any ambiguity.

On the question of permanent liaison with the British Dental Association Dr. W. E. Dornan pointed out that in addition to the British Dental Association there were two other bodies representing dentists, and, moreover, that the British Dental Association did not include the admittedly diminishing number of unqualified dentists who had been brought in under the 1921 Act. He suggested that a similar endeavour be made to reach agreement with the members of these other societies.

Dr. Waterfield said that they had reached this arrangement with the most important body in the dental world and he hoped it would be allowed to stand, but an endeavour would be made to bring these other bodies into liaison as well. The Council decided, however, to refer back to the Ethical Committee for further consideration the proposal to form a joint ethical committee with the British Dental Association.

Co-operation with Dominions

The President (Sir Hugh Lett) introduced the report of a special committee which had been considering means whereby more effective steps might be taken to deal with matters of common interest affecting practitioners in this country and in the Dominions. The need for a closer liaison, he said, had been strongly felt by the committee, which proposed that the Canadian Medical Association, the Federal Council of the Association in Australia, the New Zealand Branch of the Association, the South African Medical Association, the Medical Association of Eire, the Newfoundland Medical Association, and the Branches of the Association in Southern Rhodesia be invited to co-operate with the Council in London in the establishment of a "British Commonwealth Medical Council" for the purpose of developing and maintaining closer contact between practitioners in the United Kingdom and in the Dominions, and between medical practitioners in the various Dominions; for advancing the status of British medicine; for the discussion and exchange of views on matters of common interest, and for the promotion of an interchange of professional facilities. Each member association would appoint three representatives on the Commonwealth Council, which would meet at least once a year, the first meeting to be in London in 1948. Arising out of this, said Sir Hugh Lett, there was another important point having to do with the men who came over to London for postgraduate work and in certain cases for undergraduate work. A number of bodies were interested in these people, but there was no combination between them, and there was a certain amount of overlapping. The committee felt that when a medical man came to London on a visit from the Dominions he should be advised to go straight to the B.M.A., where he would be given information and help in various directions, on both the academic and the social side. It was not merely a question of formal arrangements for study but of giving a personal welcome. It was therefore further proposed that the principle of establishing an Empire Medical Advisory Bureau at B.M.A. House to assist practitioners, particularly those from the Dominions and Colonies, visiting the United Kingdom be approved, and that the Secretary be instructed to draw up a detailed plan for the consideration of the Council, after report by the Finance Committee.

The proposals were adopted, and the Chairman of Council expressed the thanks of the Council to the President for his able chairmanship of the committee. Mr. Arthur Porritt said that the suggestions for such a scheme had been received with the greatest enthusiasm in Australia and New Zealand. Sir Hugh Lett said that in the leading article in *The Times* of June 3 Mr. R. G. Casey was quoted as saying that no one seemed to take any interest in the Dominions—but here was the British Medical Association!

Co-ordination of Policy on Remuneration

Dr. S. Wand, chairman of the General Practice Committee, proposed the setting up of a small standing committee to which all questions relating to remuneration could be referred, after consideration by the committees primarily affected. He said that it had happened that the decisions of one committee concerning the fees or other remuneration for a particular service had had a prejudicial effect on the decisions of another committee concerning a comparable service, each committee being in ignorance of what the other was doing, and the Council was too large to be a co-ordinating body.

The Chairman of Council pointed out that this would need to be very carefully handled if it was not to mean a delaying action. A good many of the difficulties were likely to be solved with the coming of the National Health Service, in which remuneration would be dealt with from different angles by a central body covering the main subjects.

Dr. Vaughan Jones and Dr. F. Gray spoke in support of the proposal, the latter saying that he had been against it when it was first brought forward, but had been converted by events. It was very easy for action on one side, however well intentioned, to prejudice another. The proposal was also supported by Mr. R. L. Newell, who said that as chairman of the Hospitals Committee he had often been in very considerable difficulty because he had not known that other committees were discussing the same problem.

It was agreed that a small committee consisting of the chairmen of the five or six committees concerned with the various aspects of remuneration be appointed for this purpose.

Public Health

In the absence of Dr. Fenton, chairman of the Public Health Committee, the report was introduced by Dr. J. A. Ireland. The principal recommendation was that a communication be sent to Divisions and Branches suggesting a review of the rates of remuneration received by practitioners who hold appointments as public assistance district medical officers with the object, where necessary, of making representations to the local authority: (1) for salaries to be raised to a level which, allowing for variations due to changed duties, would give a 50% betterment factor as compared with pre-war remuneration for the appointment, and (2) where payment is by capitation fee, for such fees to be raised to a figure not less favourable than the present remuneration of insurance practitioners under the Insurance Acts.

Some exception was taken to the latter proposal. Dr. Vaughan Jones considered it unfortunate that the comparison with the insurance capitation fee should have been introduced; those for whom district medical officers were responsible were in almost all cases chronic invalids, whereas perhaps only half the insured persons for whom a practitioner was at risk received treatment in any one year. The Secretary explained that it was the rate of remuneration, not the capitation fee itself, which was in comparison.

The recommendation was approved.

It was also agreed to request the Ministry to amend the Measles and Whooping-cough Regulations, 1940, so that the fee for notification of cases occurring in private practice is not less than that prescribed by Sect. 145 of the Public Health Act, 1936, for other notifiable diseases. The regulations in question were a wartime measure, and the lower fee, which was the subject of protest by the Association at the time, was imposed because it was expected that there would be a large number of such notifications and it was deemed necessary to restrict public expenditure as much as possible.

On the remuneration of Scottish Public Health Medical Officers—on which subject a meeting had taken place between the Scottish Committee and representatives of associations of local authorities in Scotland—Dr. J. B. Miller, who had been present at the meeting, said that there were very few posts in Scotland—and those in comparatively small burghs—to which the equivalent of the Askwith scale did not apply, and the bonuses paid to Scottish medical officers of health were considerably higher than the bonuses paid to their English colleagues. The discussions for an interim revision of the salaries of whole-time officers had not been particularly productive, but in any case of injustice the local officer concerned would be supported in his claim for a proper salary.

Medical Care of the Child under the N.H.S.

Dr. F. Gray presented the report of a joint committee of the Association and the Society of Medical Officers of Health on the medical care of the child under the National Health Service. He said that the joint committee was agreed that the work of public health medical officers concerned with the care of children was parallel with and related in nature to the work

of general practitioners rather than that of hospitals; that both general practitioners and child health medical officers would benefit by an interchange of their respective experiences and outlook; and that, in the words of one of the "conclusions," "in the future entrants into child health work should be required to have had special training and experience in this field."

Dr. Vaughan Jones said that this report seemed to him, so far as general practitioners were concerned, not a matter of congratulation but a matter of despair. In another arena a new maternity service had been devised which would exclude all but certain selected practitioners from the practice of midwifery. They were now proposing to do the same with child welfare and infant care, and this was all the more surprising when they read in the body of the report: "In this connexion we welcome the General Medical Council's proposal (reported in the *British Medical Journal* of May 3, p. 608) to make paediatrics or child health a major subject in the general medical curriculum." The Association had said over and over again that the general practitioner at present was quite competent to practise paediatrics, and now this report appeared to be going back on that and saying that if a man was going to practise paediatrics he must have additional qualifications. The whole basis of medical training seemed to be undermined by the additional qualifications required.

Dr. Mary Esslemont challenged Dr. Vaughan Jones's statement that the maternity service scheme excluded all but certain selected practitioners; that was not a fair interpretation.

Dr. Gray said that the committee agreed that medical training had given nearly all the emphasis to the curative aspects and that in the future a revision both of undergraduate training and of postgraduate training would be necessary if family practitioners were to provide the preventive and educational service now given by local authorities. He thought it could not be disputed that at present the ordinary undergraduate training did not properly fit a man for this preventive work. It was not laid down in the report that the special training must be postgraduate, only that there must be more adequate preventive training at whatever period it was given.

Dr. Vaughan Jones pointed out that in the North there were numbers of practitioners who had infant welfare clinics in their own practice, and it was obviously unnecessary to require such men to undertake postgraduate courses and obtain special diplomas.

It was agreed to re-word the conclusion to which exception had been taken, so that it would read: "In the future entrants into child health work should have had training and experience in this field," instead of ". . . should be required to have had special training . . ."; and with this modification Dr. Gray said that he hoped the report would be accepted. In the past the Society of Medical Officers of Health had been in favour of setting up a special body of people, not general practitioners at all, for this work. They had moved from that position, and it was important that so far as was possible they should go to the Ministry with a united front.

The report, with the modification above mentioned, was adopted.

Scottish Affairs

The report of the Scottish Committee, introduced by Dr. G. MacFeat, contained a reference to the resignation of Dr. W. D. Frew on health grounds. Dr. MacFeat said that this resignation had been received with great regret. Dr. Frew's services on the Scottish Committee over a long period and on the Council for a shorter time were much appreciated.

The Secretary of State for Scotland had stated that he wanted negotiations concerning the new National Health Service to start in the following week, and the Scottish Negotiating Committee had appointed several subcommittees to undertake the consideration of different sections. On the Negotiating Committee the B.M.A. representatives constituted a majority, and there was approximately a 50% representation of general practitioners.

The Scottish Committee was at present collecting information regarding the salaries of whole-time medical officers of the public health service in Scotland, with a view to determining how far these fell short of the revised Askwith scale. Failing satisfactory results from this inquiry, the support of the Council would be sought through the refusal of advertisements for posts which did not conform to the Scottish scale plus the percentage increase.

Welsh Regional Hospital Board

Dr. H. R. Frederick, chairman of the Welsh Committee, said that information had been received, unofficial as yet but authentic, as to the medical personnel likely to be appointed by the Minister to the membership of the Welsh Regional Hospital Board.

After some debate, in which several non-Welsh members supported the strong observations of the Welsh Committee on the point, the following resolution was accepted by Dr. Frederick and unanimously carried:

That the Ministry be informed that in the view of the Association's Welsh Committee the proposed medical membership of the Welsh Regional Hospital Board is in substantial part unrepresentative of medical opinion, with the result that the Board will not command the confidence of the profession, and that the Ministry be asked for its comments.

The Services

General R. W. D. Leslie, for the Naval and Military Committee, said that the committee had given preliminary consideration to the proposals set out in the White Paper on terms of compensation for members of the Indian Civil Service in so far as it related to officers of the I.M.S., and at a later date would discuss the implications with the India Office. It had also received a statement from the War Office on the training of specialists for the regular Army. It was conveying to the medical departments of the other Services its endorsement of the final policy of the War Office, in particular that a period of up to twelve months should be devoted solely to training at a suitable teaching school, with appointment in that school if possible, at which stage higher qualification should be obtained, and again that there should be refresher courses of up to three months at a suitable teaching school approximately every three years.

The committee was asking the three Service departments for the reasons for granting a modified rate of marriage allowance to officers under 25 years of age. It was also inquiring of the Admiralty the reasons leading to the decision that the compulsory age of retirement of surgeon lieutenant-commanders should be 48 years, as compared with the age of 53 years laid down for officers of equivalent rank in the Army and Royal Air Force (majors and squadron-leaders).

WAR CRIMES AND MEDICINE

Dr. J. A. Pridham, chairman of the International Relations Committee, reminded the Council that at the International Medical Conference held at B.M.A. Headquarters last September certain delegates from the Continent had spoken of crimes committed by medical practitioners in their countries during the war. The Committee had prepared a statement on this subject which it recommended should be submitted by the Council to the World Medical Association (printed in this issue at page 131 as item No. 167 of the Supplementary Report of Council).

Dr. W. D. Steel, while applauding the general lines of the memorandum, wished that it could include the suggestion that the doctors of the world might, by united action, be able to deter governments from entering into war. By discussion in the World Medical Association some practical policy might be fashioned along those lines. Dr. J. B. W. Rowe spoke to the same effect, suggesting that doctors as a highly educated section of the community in all countries might have great influence if they co-operated in securing the outlawry of war in the world. Dr. H. H. D. Sutherland also supported the inclusion of some such principle.

After a short discussion, however, the memorandum was adopted as it stood, and the authors were congratulated, Dr. R. Cockshut saying that words of such tremendous importance had never before appeared on the Council agenda.

VARIOUS COMMITTEES

Mr. Dickson Wright presented the report of the Film Committee, which under the chairmanship of Sir Lionel Whitby had been considering the place and value of the film in medical

education, undergraduate and postgraduate. The recommendations were all agreed to as follows: That the Association establish a medical film bureau primarily to serve Divisions and Branches and to act as a central office to advise on the production of medical films and arrange for appraisals and grading; that the principle of a B.M.A. film library be approved and that a report be made on its financial implications, and that the Organization Committee be asked to consider and report on the setting up of a standing committee to manage the projected bureau and library and to deal generally with matters concerning medical films. The Film Committee was congratulated on an excellent piece of work, very carefully carried out over a period of twelve months.

Dr. Janet Aitken introduced the report of the Committee on the Care and Treatment of the Elderly and Infirm which has been sitting under the chairmanship of Dr. A. Greig Anderson during the last six months. The report submitted, although hurried somewhat in its preparation, was not an interim one. The publication has been pressed forward in view of the fact that regional hospital boards will shortly be planning the future hospital services. The report was approved, and after its publication in the *Supplement* it is to be reprinted in pamphlet form and sent to divisional and branch secretaries, members of regional hospital boards, chairmen of local executive councils, and clerks and chairmen of health committees of major local authorities. The Council also instructed that copies be sent to all Members of Parliament. The attention of the Negotiating Committee is to be drawn to the importance of securing co-ordination of the activities of the different administrative authorities concerned in this field. A special vote of thanks was accorded to Dr. Anderson, who is not a member of the Council, for his services.

The report of the Consultants and Specialists Committee, the principal matters in which were given in the report of the meeting of the committee in the *Supplement* of May 31, was approved, as was the report of the Insurance Acts Committee (*Supplement*, May 10). The report of the Hospitals Committee was a summary of the recent consideration, at a special meeting of the committee, of the future organization of hospital services under the National Health Service Act. Certain expressions of opinion as to private treatment in hospital, charge of beds, representation on committees, whole- and part-time service, and domiciliary consultations have been communicated to the appropriate subcommittee of the Negotiating Committee.

On the report of the Journal Committee, presented by Dr. O. C. Carter, occasion was taken to mention, in connexion with Dr. R. G. Gordon's retirement from the Publishing Subcommittee, the exceptionally long and effective services of Dr. Gordon in various capacities concerned with the control of the *Journal*. He hoped his retirement would be temporary. The Council endorsed the tribute of the committee chairman. A further increase of membership of the Association was reported by the Organization Committee, the membership at the end of April standing at 55,127.

Reports dealing with routine or prospective business were forthcoming from the Office, Charities, Public Relations, Staffing, and other committees. The committee recently appointed to inquire into the subject of group practices reported that it had begun its work.

Mr. Lawrence Abel, Prof. D. M. Dunlop, and Prof. E. J. Wayne were appointed to serve on the Joint Formulary Committee, which is being set up in conjunction with the Pharmaceutical Society to compile a standard *National Formulary*.

The Council appointed Dr. J. L. Gilks, the chairman of the Dominions Committee, as its delegate to attend the intra-territorial meeting of the East African Branches in September to mark the fiftieth anniversary of the arrival of Sir Albert Cook in Uganda.

The draft constitution and report of the Organizing Committee of the World Medical Association were approved, and the Council nominated its Chairman, the President, and other members to serve as delegates or alternates at the first annual meeting of the General Assembly of the Association, to be held in Paris in September. The Secretary was appointed to attend by invitation the National Food and Agricultural Organization Committee and to advise the Council.

A resolution passed by the Council of the Medical Women's Federation was laid before the members. It suggested that the principle of conscription as affecting male doctors should apply equally to women doctors, and requested the Government to receive a deputation with a view to the amendment of the National Service Bill in this direction. The Council of the B.M.A. agreed that the Federation's point of view should be supported.

The meeting of the Council lasted from 10 a.m. to 5 p.m.

MEDICAL ORGANIZATION IN DENMARK

GENERAL CONSIDERATIONS

BY

OLE BANG, M.D.

Chief Physician, Randers, Denmark

Conditions in Denmark have favoured the building of a sound medical system. Untouched by the first world war, and with confidence in the protection yielded by the League of Nations, we seemed free to direct our attention towards social development. Furthermore, a small country like ours, with a uniform population of about four million—of which about 4,000 are doctors—offers good opportunities for planning and management. Last but not least, we feel that our long-established thoroughly democratic mode of living has been an essential basis for all the progressive work in this field. We were spared major devastations in the last war, and perhaps our need for rebuilding has not engendered an impulse towards social reorganization so powerful as that experienced in Great Britain. So far we have managed to return to the course steadily followed in pre-war days. Nevertheless there is a rising wave of political interest in the field of medical organization—as exemplified in the new Hospital Act of 1946—and though the efforts of the politicians are not at present so determined here as they seem to be in Great Britain, Danish doctors are on the alert and feel the necessity for establishing the medical profession in a position which enables us to control and co-operate in the development. From experience we feel confident that no administration can in the long run do without the expert guidance offered by a responsible representation of the medical profession.

Socialization of the medical profession has already been carried far by a gentle and slow yet steady process, mainly through our sick insurance scheme and communal hospital system. There is considerable difference between our condition and what is usually understood by "State medicine." Our system has important "safety valves," and the co-operation of the Medical Association has always been deemed necessary by health authorities. The medical profession does not react against a natural evolution of the organization necessary in order to secure for the population the best possible health service and medical care. It directs the attention of authorities to points where medical progress or changing social conditions call for reorganization of the system. On the other hand the profession is strongly and unanimously opposed to any measure not justified by real improvement for the population or bearing the hall-mark of political opportunism or experiment. The distance between our system and State medicine, with the doctor as a Civil Servant, may be covered step by step in future development if demanded by the general trend in social evolution. So far, however, there is no obvious need to advance further along this path, and in resisting any revolutionary step the profession feels in accord with the wishes of the people.

The Danish doctor has a good position socially. He is well esteemed, trusted, and frequently beloved by his patients. His means are such that he can afford to give his children the best education available; and, if a general practitioner, he is pensioned through a special contract with panel institutions. In the capital he is freed from night calls by the organized night-watch schemes, and holiday duty is arranged in turns. In the provincial cities conditions are somewhat less favourable, and in rural areas a real vacation is difficult to obtain, since a locumtenent is not readily found; in fact, several country doctors go on year after year without vacations.

The Family Doctor

The Danish doctor is also a very busy man. The general practitioner is regarded as the foundation stone of the campaign against disease, and so is engaged in health control and prophylactic measures besides his ordinary tasks as a family doctor. It is true that the amount of desk work which he is called upon to carry out, such as certificates, prescriptions, reports, etc., threatens to leave him too little time for his patients, re-education, and vacations; and there is much criticism of and fight against the "bureaucratic weeds" of a not always elastic administration.

Danish patients on the whole are reasonable and understand well the proper use of the medical aid offered to them. A few may be exacting in their demands, feeling they have a right to this and that, and admittedly some doctors spoil their patients by paying too many visits and the like in order to compete against colleagues. Most doctors, however, have quietly educated their clients towards a considerate relationship—if not to the docility known by our fathers in the times when a doctor was a little king in his area. When complaining about thoughtless patients it is well to remember that you cannot carry on propaganda for medical examination with a view to obtaining early diagnosis of appendicitis, cancer, tuberculosis, etc., and at the same time blame the patients for troubling the doctor with what turn out to be trifling or ridiculous symptoms. More and more doctors manage to employ a female secretary, who assists in the consulting-room and with files and accounts; doctors' wives, however, must often function in that capacity. The organization of home nurses, supported by the communes and regulated by the Health Service, is advancing slowly at present, but home nurses already constitute a valuable asset.

On the whole it may safely be maintained that the health of the population is being well looked after. A watchful and conscientious corps of general practitioners, aided by laboratory, *x*-ray, and other facilities, contrive to keep the standard of their work at a high level. This excellence, as well as legislation, is mainly responsible for the fact that quacks are few and their activities almost negligible. The hospitals, jealously watched over by the National Health Service, are in good order, and hospital treatment is available to any patient in need of it. The public health service is extensive and modern in its control measures. Finally, the General Danish Medical Association is a strong body, with adequate means of keeping members within bounds (for example, panel contracts depend upon Association membership), maintaining the morale of the profession, and retaining its influence and initiative in medical organization. We do not regard our organization as perfect, but it at least has the advantage of having been proved through many years of practical experience.

HEARD AT HEADQUARTERS

Dr. Hill for Parliament

Dr. Charles Hill has been invited to become Parliamentary candidate for the Luton Division of Bedfordshire at the next General Election. The invitation is a combined one from the Luton Division of the Bedfordshire Liberal Association and the Luton Parliamentary Conservative Association, bodies which have recently been fused. It was addressed to Dr. Hill not as Secretary of the British Medical Association but as a local resident with many interests and attachments in the district. Until the last election Luton was a shuttlecock of the older parties, being Liberal and Conservative in turn. For several years Dr. E. L. Burgin, Minister of Supply in the War Government, represented it, first as a Liberal and later as a Liberal Nationalist.

Mounting Membership

The Association membership goes on rising. During the months of March and April there was a net gain of 600 members, and at the end of April the total figure stood at 55,127. As the result of a recruiting circular issued at the end of last year over 800 applications for membership were received. More recently another small effort has been made, following the increase in the capitation fee, to bring in those relatively few insurance practitioners who have remained outside the Association. They have been reminded of what the Association has done on their behalf; for its achievements, like the blessed rain, fall upon the just and the unjust. This has produced already some 90 applications. The Council at its June meeting elected 56 members, mostly Service doctors, who do not go through the ordinary Branch procedure of election. The membership of the Association is now about 20,000 more than it was ten years ago.

Examination Time

The time taken to fill in a medical report depends, obviously, upon two main factors—the length and nature of the form and the care and conscientiousness which the examiner brings to the task. A question arose the other day on the time taken to fill in the form of medical report required under the established service scheme for merchant seamen. The form consists of 38 spaces to be filled, though a number of them of course depend on information from the man himself. They include, however, particulars of near and distant vision, colour vision, cardiovascular system, pulse, blood pressure, and nervous and genito-urinary systems; and the fitness of the candidate has to be assessed under one of four headings. A medical officer of the Shipping Federation suggested that such an examination could be completed in twenty minutes, which was derided by an independent doctor as ludicrously insufficient. But another independent doctor who had had experience of such examinations said that in such cases, although the time in each case might vary, it was remarkable how they worked out at three examinations to the hour.

Back to the Gold Standard

It was a matter of regret to the Association that when the late Sir Kaye Le Fleming was awarded the Gold Medal in 1941 the Royal Mint was precluded from making medals in gold, and only the illuminated address which goes with it could be given to Sir Kaye. The impracticability of obtaining a gold medal continued until the end of the war and after, so that it was not possible to present the medal to Sir Kaye before his death in 1946. A gold medal has now, however, been obtained, and arrangements have been made for the presentation to Lady Le Fleming at the forthcoming Annual Meeting in London. The Gold Medal of the Association was instituted in 1877, and at first it was given to doctors who had performed deeds of gallantry on the field of battle or in mines. The first recipient, Dr. H. N. Davies, was a doctor who had acted heroically in a mining disaster at Pontypridd. The first scientific recipient, so to speak, was Dr. William Farr, the statistician and sanitarian, and the first to receive the Gold Medal for prolonged service to the Association and the profession were, fifty years ago, Mr. C. G. Wheelhouse, of Leeds, a former Chairman of Council, and Sir Walter Foster, afterwards Lord Ilkeston. Of the four living holders, three received the medal for conspicuous service to the Association, and one, Major A. Martin-Leake, V.C. and bar, for bravery and devotion to duty on the field of battle.

Better Pay for Anaesthetists

Now that the pay of specialists, and the relation of pay in different branches, is very much to the fore, a development in Middlesex is interesting. Anaesthetists have complained that their scale of pay in local authority service is below that of other senior clinicians. Some time ago the Middlesex County Council, one of the most progressive of bodies in its health service, was criticized in our correspondence columns because the salary of its whole-time senior anaesthetists in the council hospitals was £1,000, rising by increments of £50 to £1,400 per annum, and thereafter on proof of outstanding achievement by further increments of £50 to £1,600. At a recent meeting the Middlesex County Council on the recommendation of its Public Health Committee agreed to amend this scale to a salary of £1,000, rising by increments of £100 to £1,600, and thereafter on proof of outstanding achievement by further increments of £50 to £1,800. This brings it more closely in line with the salaries paid to other senior clinicians in the Council's service.

Correspondence

Alien Doctors

SIR,—Serving as a private soldier in the R.A.M.C. I travelled from Bristol to Southampton in November, 1940. It was a Saturday night and an air raid was in progress. The common danger loosened the tongues. Selfconscious of my imperfect knowledge of the English language, I kept silent and pretended to sleep. The sound of an explosion near by rather shook us, and I had to wake up. My fellow travellers made a good deal of fuss about me and my compatriots generally. They thought it was praiseworthy that we did not want to live under the heel of the Germans, and they regarded our presence in this country as a help.

Three years later, on leave in this country, I was invited to say a few words at a Royal Empire Society meeting. Being a foreigner I did not feel competent and justified in doing so, and I said so. "You are not a foreigner, you are an ally," said the chairman. It is a very good feeling to be recognized as an ally; and it is a very bitter feeling to be degraded again to an alien and foreigner.

I am quite conscious of the fact, of course, that your readers won't be disturbed very much by our feelings. If our wartime service has not convinced them of our loyalty to this their wonderful country, nothing will ever—not the fact that we learned their language, not that we passed their medical examinations, not that we married their daughters (or rather their daughters married us), not that we have applied for British citizenship, and not that our children are British born. We are aliens again. We are foreigners again; as a matter of fact we are unwanted foreigners (although few say so, many act accordingly). Wartime friendships? Comradeship of khaki? Hopes to rebuild our world? *Omnia perdita est.* . . .

EX-CAPT., R.A.M.C.

Extension of N.H.I.

SIR,—It is strange that when we are on the verge of bankruptcy we decide to build an entirely new medical service and to cast off the benefits of the one we have, a remarkably efficient national health insurance service so organized as to necessitate the minimum of official interference between doctor and patient.

As it functions at present the N.H.I. service suffers from two main disadvantages: (1) it has no specialist services and commands no hospital beds; (2) it is available to only a small proportion of the population. If the Government would correct these two faults we could guarantee from experience an efficient and workable medical service *with our present resources.*

The specialist services could be supplied by an extension of the capitation system to include specialists; or hospitals could be provided with sufficient funds to enable them to pay the salaries of whole-time specialists. If these members of our profession found it possible by whole-time hospital work to make an income comparable with their present one, they would be willing to spend more time in hospital and could see more patients, increase the "turn-over" of the hospital, and reduce the individual patient's waiting time. A direct extension of the present N.H.I. system to include wives and children would be a simple step in organization and would involve not too much extra work for the panel doctors. In a matter of 10 years or so a further extension to include those with incomes up to £1,000 per annum would involve little dislocation of the service, and in a further 10 years the final extension could be made to include all the population.

Perhaps at this stage it is futile to make these suggestions, but with rumours of a postponement of State medicine because the organization will not be ready, with the possibility of a breakdown of the services due to national financial difficulties, with the certainty of a tremendous upheaval in the profession and an inevitable deterioration in efficiency, it is surely better to make haste slowly, use the organization we have, involve ourselves in the minimum of expenditure, and have the fairly certain knowledge that we are providing a better service than at present because we are recognizing its faults and attempting to correct them instead of incurring the risk of producing an entirely new series of disadvantages by embarking on a major national experiment at a time of great national emergency.

We must recognize that the wives and dependants of the present insured population urgently require a form of insurance medical service, and it is obvious to us all that a mere alteration of the present eligibility could provide them with that service in a matter of days and at little, if any, extra cost to the country. For the remainder of the population the need is not urgent, and this surely is a time for us to cut the national coat according to the prevailing scarcity of the cloth.—I am, etc.,

Brackley, Northants. A. CRAWFORD MAYER.

Consultants and the N.H.S.

SIR,—Dr. L. K. Crow (*Supplement,* May 10, p. 98), an old friend and war years colleague of mine, certainly has brought up a very important issue in connexion with your proposed new Health Service. Anyone knowing Dr. Crow as I do, and knowing his sincere and frequent anxieties in the matter of referral of patients to consultants when one did have the choice, would realize the dilemma with which he and other practitioners of his high calibre will be faced.

The choice of the proper consultant for each case is one which should be completely in the hands of the general practitioner. Many practitioners deliberate longer on the choice of a consultant than on the choice of a drug—and rightly so, as this choice in many cases is the deciding factor in the subsequent therapy and management of the patient.

I send the profession in Britain my best wishes in the working out of the new Health Service. I also send my best regards to all my British medical friends and former associates. —I am, etc.,

New York. HAROLD E. KLEIN.

Buying of Practices

SIR,—Dr. T. H. Hargreaves (*Supplement,* June 7, p. 116) repeats the glib statement that up to 100% of the price of a practice may be obtained at a low rate of interest. I have heard this stated so frequently—usually by elderly practitioners who cannot have tried themselves to obtain such a loan without financial backing. Provided a young doctor has wealthy friends or relations willing to guarantee his overdraft it is easy enough, but what of the man who is not so fortunate? He cannot get a loan of 100% plus sufficient to tide him over the first three months—at least I have never heard of a bank or insurance company which will do so. Whatever may be the rights or wrongs of buying and selling of practices, the lot of the man without capital or a wealthy backer behind him must indeed be very hard.—I am, etc.,

Shoreham-by-Sea. J. MICHAEL JONES.

Basic Salary

SIR,—An important aspect of the impending Health Act, to which I have not seen any reference made in the medical Press, is the legal position of a doctor (who is in receipt of a basic salary) with regard to his right to refuse to accept patients for treatment. One of the great advantages of the capitation system is that a doctor is at perfect liberty to refuse to accept patients, as the only remuneration he receives is the capitation fee for each panel patient on his list, and if he has no panel patients he draws no public remuneration.

If, however, the doctor receives a basic salary, no matter how small, will he not be legally obliged to accept any patient who applies to him to be accepted, in view of the fact that he is receiving remuneration from public funds? If this is not the case, one might have the absurd situation of a doctor receiving a basic salary and refusing to accept any patients. One rather gets the impression that if the principle of a basic salary is accepted, the "free choice" about which so much has been said will be a one-sided affair, open only to the patients.—I am, etc.,

Manchester. JAMES O'GRADY.

The memorandum of recommendations on remuneration of medical practitioners engaged by local authorities on a sessional or case basis (*Supplement,* March 22, p. 38), which was agreed to at conferences held at the Ministry of Health between the various associations of local authorities and the B.M.A., has been accepted by the Ministry of Education, as an interim measure without prejudice to subsequent negotiations, to apply from Nov. 1, 1946.

B.M.A. LIBRARY

The following books have been added to the Library:

Adriani, J.: The Chemistry of Anaesthesia. 1946.
Barach, A. L.: Principles and Practice of Inhalational Therapy. 1945.
Barnes, R. W.: Endoscopic Prostatic Surgery. 1943.
Becker, H.: German Youth: Bond or Free. 1946.
Berg, G.: The Prognosis of Open Pulmonary Tuberculosis: a Clinical Statistical Analysis. 1939.
Bremer, G.: Effect of Denervation of Teeth in Monkey and Dog. 1938.
Brown, J. A. C.: The Distressed Mind. 1946.
Buchanan's Manual of Anatomy: Edited by F. Wood Jones. Seventh edition. 1946.
Callow, A. B.: Food and Health. Third edition. 1946.
Codina-Altes, J.: Il Ponencia Cor-Pulmonale. 1944.
Courville, C. B.: Pathology of Central Nervous System. Second edition. 1945.
Cullen, S. C.: Anesthesia in General Practice. 1946.
Delay, J.: Les Dérèglements de l'Humeur. 1946.
Dingwall, E. J.: Racial Pride and Prejudice. 1946.
Duhot, E.: Les Eaux Minérales et l'Organisme Humaine. 1946.
Emerson, H.: Local Health Units for the Nation. 1945.
Fash, B.: Body Mechanics in Nursing Arts. 1946.
Fauchard, P.: The Surgeon Dentist; or, Treatise on the Teeth: Translated from second edition. 1946.
Flagg, P. J.: The Art of Resuscitation. 1944.
Gray's Anatomy: Descriptive and Applied. Edited by T. B. Johnston and J. Whilles. Twenty-ninth edition. 1946.
Hamilton, A., and Johnstone, R. T.: Industrial Toxicology. Edited by H. A. Christian. 1945.
Hardy, J. A.: Synopsis of the Diagnosis of the Surgical Diseases of the Abdomen. Second edition. 1945.
Harries, E. H. R., and Mitman, M.: Clinical Practice in Infectious Diseases. Third edition. 1947.
Hauduroy, P.: Inventaire et Description des Bacilles Paratuberculeux. 1946.
Haultain, W. F. T., and Kennedy, C.: Practical Handbook of Midwifery and Gynaecology. Third edition. 1946.
Hewetson, J.: Ill-Health, Poverty and the State. 1946.
Knyveton, J.: Man Midwife: the Further Experiences of John Knyveton, M.D. 1946.
Leyel, C. F.: Compassionate Herbs. 1946.
McCabe, J.: The Testament of Christian Civilization. 1946.
McDonagh, J. E. R.: The Nature of Diseases Up-to-Date. 1946.
McGregor, A. L.: A Synopsis of Surgical Anatomy. Sixth edition. 1946.
Moore, R. A.: A Textbook of Pathology. 1945.
Morton, R.: Shall We Live or Die? 1946.
Napier, L. E.: The Principles and Practice of Tropical Medicine. 1946.
Nicholls, L.: Aids to Tropical Hygiene. Third edition. 1946.
Parry-Price, H.: A Short Handbook of Practical Anaesthetics. 1946.
Schoenheimer, R.: The Dynamic State of Body Constituents. Second edition. 1946.
Shaw, M. M.: He Conquered Death: the Story of Frederick Grant Banting. 1946.
Slavson, S. R.: Recreation and the Total Personality. 1946.
Soffer, L. J.: Diseases of Adrenals. 1946.
Trueta, J.: The Spirit of Catalonia. 1946.
Williams, J. F.: Personal Hygiene Applied. Eighth edition. 1946.
Worral, R. L.: The Outlook of Science: Modern Materialism. Second edition. 1946.
Young, K.: Handbook of Social Psychology. 1946.

The Annual Meeting of the Medical Insurance Agency was held at B.M.A. House on June 10, 1947. The business of the Agency in 1946, as disclosed by the audited accounts, far surpassed all previous records. The profits available for distribution to the medical charities, and *a fortiori* therefore the rebates of premium granted to the clients of the Agency, were much larger than ever before, though the total of the former was heavily diminished by the incidence of E.P.T. Covenants were sanctioned with the Royal Medical Benevolent Fund and with Epsom College to a total of £4,200, benefiting the charities (on recovery of income tax) to about £8,000. A request from the Indian Medical Association for the establishment of an Indian Branch of the Agency was not acceded to, though the implied compliment was appreciated. It was felt that in the present state of political affairs in India the proposal is not practicable. Sir Maurice Cassidy, Sir Arnold Stott, and Prof. McNee were elected to the Committee of Management for three years: Dr. J. W. Bone, Dame Barrie Lambert, Dr. Henry Robinson, Dr. Charles Hill, and Dr. E. R. C. Walker were re-elected for the same period. Sir Robert Hutchison, who has been Chairman ever since the late Sir Humphry Rolleston resigned some years ago, asked not to be re-elected but remains a member of the Committee; Dr. James Fenton, C.B.E., was elected in his stead, and a very cordial vote of thanks was passed to Sir Robert for his services in the Chair. Dr. Henry Robinson was re-elected Honorary Secretary; a vote of thanks to him and to the whole of the paid staff, especially the Manager, Mr. A. N. Dixon, A.C.I.I., concluded the proceedings.

H.M. Forces Appointments

INDIAN ARMY MEDICAL CORPS

Captain E. J. Pell, M.B.E., late I.M.D., has reverted to the retired list and has been granted the honorary rank of Major.

COLONIAL MEDICAL SERVICE

The following appointments have been announced: P. B. Adamson, M.B. B.S., Medical Officer (Pathologist), British Somaliland; A. A. Alderdice, M.B. B.S., Medical Officer, Grade A (Physician) Trinidad; A. A. Byrne, L.R.C.P.&S.I., and J. Cameron, M.B., Ch.B., Health Officers, Malaya; N. G. D. Campbell, B.M., B.Ch., Medical Officer, Sierra Leone; P. Harris, M.B., Ch.B., Medical Officer, Kenya; H. R. Hudd, M.B., B.Ch., Medical Officer, Tanganyika; E. G. Hudson, M.R.C.S., L.R.C.P., Medical Officer, Anaesthetist, Malaya; W. R. Rochester, M.B., B.S., Medical Officer, Sierra Leone and Gambia; H. W. Wyile, M.B., Ch.B., Medical Officer, North Borneo; M. Allerhand, M.D., Medical Officer, St. Lucia, Windward Islands; F. G. Domainque, M.B., B.S., Medical Officer, Mauritius; T. J. Gilmore, M.R.C.S., L.R.C.P., Medical Officer, Falkland Islands; R. S. McClelland, M.B., B.Ch., Medical Officer, Northern Rhodesia.

Association Notices

Branch and Division Meetings to be Held

METROPOLITAN COUNTIES BRANCH.—At B.M.A. House, Tavistock Square, W.C., Tuesday, July 8, 2.30 p.m. Eighty-ninth Annual General Meeting. Agenda: Report of Branch Council for the year 1946–7; report of Branch representatives on Central Council, 1946–7; report as to elections of officers for 1947–8; address by incoming President.

NORTH OF ENGLAND BRANCH.—At Royal Victoria Infirmary, Newcastle-upon-Tyne, Thursday, June 26, 7.15 p.m., Clinical Demonstration by Dr. W. G. A. Swan: Thyrotoxic Heart Failure; 8.45 p.m., Address by Mr. A. Lawrence Abel: Some Common Diseases of the Rectum and Anal Canal.

Meetings of Branches and Divisions

WESTMINSTER AND HOLBORN DIVISION

A scientific meeting was held on May 15, with Dr. W. A. Milligan in the chair. Mr. Ralph Marnham, F.R.C.S., gave an address on "Some Common Rectal Conditions."

Mr. Marnham said that rectal conditions were not treated early enough. 65% of patients complained of haemorrhage, 15% of pain, and 10% of irritation. Examination consisted of inspection, by which one could see pruritus in any of its three stages, perianal haematomata, or external piles so-called, the external openings of a fistula or a fissure, possibly venereal, or a prolapsed pile. Palpation might show a sphincter in spasm. Internal examination showed also the state of the other pelvic organs, but uncomplicated piles could not be felt. The proctoscope revealed these, the state of the mucosa, and fistulous tracks. Sigmoidoscopy should be done in all cases but might be anatomically impossible in a small proportion. It excluded a growth in the last 25–30 cm. of the intestinal tract. It could be a tiresome task, but not unfruitful in showing early carcinomas or polyps. It must be insisted upon if symptoms persisted or before operations in the area.

Pruritus could be caused by local pathological causes, diabetes, or psychogenic causes. 70%–80% of cases were caused by dirt and were cured by keeping the parts clean. Patients should be warned to pinch the skin, instead of scratching, for irritation. If there was much skin change, the parts should be infiltrated with "proctocaine" or sclerosing fluid. *X* rays and psychiatric and operative treatments were of use, but a few cases were incurable. Anaesthetic ointments made the condition eventually worse. Cocaine ointments must never be used.

For perianal haematoma, if very painful, a local anaesthetic allowed the top to be cut off and the clot evacuated. For piles, except in early cases, which could be cured by sclerosing fluids, such as quinine-urea or 5% phenol in almond oil, operation was advised. Those cases where the piles prolapsed on defaecation were relieved but not cured by injections and came to operation eventually. Worse cases always needed operation. If proctocaine was injected at the time of operation and the bowels caused to act early after, the post-operative course was only one of discomfort. Fissures were sometimes cured, if early, by injection of an anaesthetic; otherwise operation was needed. Polyps, easy in children, might be difficult in adults; here the diathermy knife helped.

The condition known as proctalgia fugax occurred mostly in women; it caused a most agonizing pain, waking the patient at night. No cause had been found for this spasm of the sphincter, but it could always be relieved by passing a rectal dilator. Concerning proctitis he said the acute non-specific type was rare and responded to sulphonamides, 10 g. in water to 3 oz., as an enema morning and evening for 14 days plus parenteral penicillin.

A vote of thanks was moved by the chairman and passed with acclamation.